Barchester Healthcare Homes Limited

Bushey House Beaumont

Inspection report

57-59 High Street
Bushey
Hertfordshire
WD23 1QN

Tel: 02084218844
Website: www.barchester.com

Date of inspection visit:
12 September 2018
27 September 2018

Date of publication:
27 November 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 12 and 27 September 2018 and was unannounced. We visited Bushey House Beaumont on 12 September 2018, however received further information of concern following the inspection. On 27 September 2018 we followed up these concerns with telephone calls to people's relatives. At their last inspection on 15 December 2015, the provider was found to be meeting the standards we inspected. We rated the service overall as good. At this inspection the service overall rating had changed to requires improvement. At this inspection we found breaches of regulations 12, 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. This was because people experienced delays receiving their care and medicines, complaints were not responded to and a system of governance was not effectively managed.

Bushey Beaumont is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bushey Beaumont accommodates 62 people across two separate units, each of which have separate adapted facilities. At the time of the inspection 44 people were living in the home.

The service did not have a registered manager in post. The previous manager left in February 2018. A new manager had been appointed two weeks prior to this inspection and would apply to register as the manager following this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People were not consistently supported to live in a safe environment. People's call bells to request assistance were not responded to promptly and staffing was not effectively monitored or deployed. People did not receive their medicines as prescribed. Staff were aware of the risks to people's health and wellbeing and measures were in place to manage these safely. People were supported by staff to be safe living in the home. Staff were aware of when to report any concerns about people's safety. People lived in a clean and well-maintained environment and were cared for by staff who followed infection control procedures.

People's consent to care had not consistently been sought in line with the legal requirements where they lacked the capacity to provide consent. People's dietary needs were not always well managed. However people were supported appropriately by staff to eat and drink sufficient amounts. A range of health professionals supported people's health needs when required, however follow up appointments were not always made. Staff received training in key areas to support them in their role, and staff received appropriate support from their line manager.

Complaints were not responded to in a timely manner and some people and relatives had lost confidence in

raising their concerns. People's social needs were not always met, particularly when people chose to not participate in group activities.

The service had undergone a period of instability whilst recruiting a permanent manager. People and relatives did not all think the service was well managed. However, they were positive about the recent appointment of the manager. Systems and processes to monitor and improve the quality of care had not been effectively managed. Notifications of significant incidents had not been submitted in a timely manner as required.

People's dignity and privacy was mostly met and staff interactions were kind and considerate. Care staff supported people patiently and sensitively and enabled people to remain independent.

The service had undergone a period of instability whilst recruiting a permanent manager. People, relatives and staff did not all think the service was well managed, however they were positive about the recent appointment of the manager. Systems and processes to monitor and improve the quality of care had not been effectively managed. Notifications of significant incidents had not been submitted in a timely manner as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People needs were not promptly responded to when they called for assistance.

Staffing levels were not effectively monitored to ensure staff were effectively deployed.

People's medicines were not consistently managed and administered safely.

Risks to peoples safety and welfare were identified and monitored and measures were in place to reduce these risks.

People were cared for in a clean and well maintained environment.

Staff had undergone robust recruitment checks before starting work.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always follow the requirements of the Mental Capacity Act 2005 when seeking consent from people unable to provide this.

People's specific dietary needs were not consistently met as the kitchen staff were not always made aware of people's dietary needs.

Staff were sufficiently trained to support people with their needs.

People were able to access healthcare service when needed.

People lived in an environment that was well-maintained and adapted to meet their needs.

Is the service caring?

Good

The service was caring.

People were mostly treated in a dignified and sensitive manner.

Staff knew people well and listened to their views and opinions about their care.

People's privacy was respected and maintained.

People were able access advocacy services to support their decision making if they wished.

Peoples confidential information was kept secure.

People's relatives and visitors were able to visit freely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples concerns and complaints were not responded to.

People did not all feel involved with developing their care.

Not all people were supported to pursue interests and activities within the home.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was not a registered manager in post.

The absence of a registered manager had led to a deterioration in the management of the service/home.

People did not feel the service had been well managed in the absence of a permanent manager.

Peoples views and opinions about the running of the service had not been sought.

Effective systems were not operated to ensure care provided was safe.

Notifications were not submitted to CQC in a timely manner.

Bushey House Beaumont

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 was prompted in part by concerns raised with us regarding unsafe staffing levels and people waiting long periods to receive care. This inspection examined those risks.

Before the inspection we reviewed information, we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We sought feedback from the local authority commissioning team and safeguarding team. We spoke to people's relatives who had raised concerns with CQC.

The inspection was carried out on 12 and 27 September 2018 and was unannounced. On the 12 September 2018 the inspection was carried out by two inspectors a specialist advisor and an expert by experience. The specialist advisor had clinical experience of nursing care for people. An expert by experience is a person who has experience of using this type of service, and sought the views and opinions of people and their relatives. We received further information of concern regarding safe care and staffing levels and spoke with a further three people's relatives on 27 September 2018.

We spoke with nine people and seven people's relatives. We spoke with eight members of staff, the deputy manager, the newly appointed manager and representatives of the provider. We viewed information relating to seven people's care and support and reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt the service provided was safe. One person said, "Absolutely safe, 10 out of 10." A second person said, "It's safe, I have not had any concerns about anything." However, we found that people were not supported by sufficient numbers of staff. One person told us, "There are not enough staff on in general at this care home. They are particularly short in the morning from 7 o'clock to 11 o'clock." A second person said, "The care staff are excellent the exception is them taking a long time when I ring the bell for them to attend. One person's relative told us, "[Staff] are very busy at times especially in the morning. They should have more staff on at these busy times."

Most of the staff we spoke with told us there were not always sufficient staff. One staff member told us, "There are not enough staff, people are becoming more dependent on us, but [Managers] don't see that and we struggle on understaffed." One person had been allocated one to one care as they had fallen on a number of occasions previously. However, we were advised by the persons relative that, "Beaumont don't seem to grasp the concept of what One to One entails and my [family member] has been left on their own while carers go off for a break and forget to go back to them."

Staff were constantly busy, having very little time throughout the day to spend any meaningful time with people. Staff told us it was common for them to cut short their breaks, or not take these at all. One staff member said, "How can I stop for lunch, we have to help them eat, then help with personal care, then move onto the next, there's not enough staff around to help." A person's relative told us they did not feel that their relative was bathed regularly. They told us they had arranged for a private nurse to come in at least twice per week to bath and shower their relative. They told us," This is in the care plan [For twice weekly bathing] but unless we, the family pay an outside nurse to do this it would never happen. All they [Care staff] do is give my [relative] a sponge rub down, but no one feels really clean or refreshed with a rub down sponge bath at the side of the bed."

We looked at a summary of the call bell logs. These identified the call bells that had been ringing for over six minutes. We asked the manager why they did not identify calls until six minutes had elapsed. This meant that through monitoring a person may be left in need of assistance for this period of time. They did not know, and told us this was the policy. They told us they would review this. The records for responses to call bells showed significant delays in responding to people. Times recorded ranged from six minutes up to over an hour in some examples. We asked the manager to take immediate action to address this issue. We found that despite these delays people had not experienced any harm such as developing a pressure wound, but were at risk of this due to the length of time they were left unattended.

Staff told the manager they were unable to hear the call bells, and there were not enough pagers to alert them. The manager promptly ordered replacement pagers to ensure there were sufficient available. They reassessed the dependency levels within the home, however, this tool showed the home being overstaffed by nearly thirty hours. Staffing had been increased where two people had recently moved in, but these actions had little impact on the responsiveness of staff. When planning the deployment of staff in the home, little consideration had been given to the layout of the building, administering medicines, or allowing

sufficient time with each person. The dependency assessment allowed just over three hours care per person in a 24-hour period. Clearly this was not enough as the continued delays demonstrated.

Due to the deployment of staff that resulted in significant delays to people receiving assistance this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not consistently managed and administered safely. Due to the way staff were deployed we saw both the morning and lunch time medicines rounds took over three hours to complete. Two staff were responsible for administering medicines across the two sides of the home. One staff member said that the medicines round took between 2-3 hours as people often had many medicines that took time to swallow. The staff added that due to some medicines needing two nurses' signatures that this increased the time taken One person for example required regular medicines throughout the day to support them at the end of their life. The registered manager told us that a new staff member would soon be assessed as competent to undertake the role of a second signatory.

Medicines that were prescribed to be given with food and just after eating were not and people waited nearly an hour after eating. This would reduce the efficacy of the medicine. The timing of the administration of medicines did not allow sufficient, evenly spaced time to them to be given as the prescriber intended.

People were prescribed a range of medicines to control their behaviour, assist them to sleep or manage their dementia. A review of these prescriptions had not been completed for a significant period of time and where changes had been recommended, these had not been acted on. In addition, people had not been referred to the appropriate health professional. This meant that people's behaviours were being managed through medicines, as opposed to following good practise. One person at times displayed agitation and aggression due to their dementia. Their medicines were reviewed in April 2018 and the recommendation was to change the medicine and to further refer to Mental Health services and to ask for support from the palliative care to manage their pain. Care records looked at and staff confirmed these actions had not been carried out. This was a breach of regulation 12 of the health and social care act 2008 [Regulated Activities] regulations 2014.

Staff told us they had safeguarding training and felt skilled and knowledgeable about this and keeping people safe from harm. The majority of staff demonstrated to us a good understanding of keeping people safe, preventing and recognising the different types of harm and neglect, and all told us they would report their concerns to management. However, some of the staff spoken with were not as confident in identifying where a person may be at risk of harm. For example, one staff member was not able explain to us what the types of harm were, and when asked about safeguarding told us, "That's above my pay grade." At a recent staff meeting the manager had emphasised to staff the need to report any harm or neglect promptly.

Incidents when reported were not all consistently reviewed, investigated and responded to. This was because incident reports had been filed away without being robustly reviewed or thoroughly investigated. This meant that where incidents occurred there were missed opportunities to share and learn lessons. This limited the potential to prevent further occurrences

Staff were aware of all the risks involved when supporting people such as for a walking frame or hoist. We saw risks were appropriately assessed, reviewed and managed for subjects including choking, fire and evacuation and risks related to pressure areas, incontinence, hydration and nutrition. For example, where people required hoisting the risk assessment noted the number of staff required, the sling size, and which hoop to use.

The home was well maintained, bright, clean and airy. Domestic staff ensured people's rooms and communal areas were cleaned thoroughly and malodours were not present throughout the home, other than in the persons room we have reported in the caring domain. People told us that staff followed strict infection control procedures when caring for them, and staff were seen to use the appropriate equipment. Sufficient stocks of cleaning equipment were in place. The manager as part of their daily walk rounds undertook regular checks of cleanliness to ensure the standards of hygiene were maintained.

Staff recruitment checks were carefully-structured. We saw evidence of staff's identity had been verified and criminal records checks had been carried out. Staff who worked in the home from overseas had the appropriate documentation to ensure they were able to work without restriction. Records of recruitment interviews demonstrated that management staff had explored relevant aspects of staff experience and values. References had been requested and management ensured the professional registration of nursing staff was current.

Staff had received training in relation to fire safety and were aware of how to safely evacuate people in the event of an emergency. Equipment needed to transport people unable to mobilise was available along with individual evacuation plans. Fire drills and regular servicing of equipment and alarms had been carried out.

Requires Improvement

Is the service effective?

Our findings

People told us staff sought their consent prior to providing them with support. Care records we looked at had been signed by the person providing their consent, and people told us staff explained what they needed to do and the reason for this. We observed throughout the inspection staff obtaining people's verbal consent prior to assisting them. Staff were seen to clearly explain and waited for the person to respond when the assisted them. Where people declined personal care for example and told staff they were not ready or did not wish to be assisted at that time, then staff acknowledged this and returned later.

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 found that not all staff were knowledgeable about the principles of the MCA and they had not consistently followed best interest processes to help ensure that the way people received care and support was in their best interest. One staff member told us that the MCA was "for more for qualified staff." MCA and best interest decisions were not always clearly documented in people`s care plans. The manager had not checked to make sure that people's lasting power of attorney (LPA)had been verified and that the LPA was valid and registered with the official body. This meant they could not be sure the decision made was legal. This was an area the manager was aware of and was in the process of inviting families or advocates into the home to review these.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that for people who had DoLS authorisation in place these ensured that the least restrictive methods were used when people were deprived of their liberty.

People's needs and choices were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Nursing staff informed us how they continued to stay up to date with nursing practices and procedures to achieve effective outcomes. Comprehensive assessments and pre-admission assessments were carried out, which included any surgical history. The person's needs were identified with their input and a person-centred care plan created, which was reviewed and updated regularly. Care plans included details of personal care, pressure care and other health related needs, along with equipment required to help a person communicate (for example glasses and hearing aids).

People told us they felt staff were sufficiently trained to effectively provide them with the care and support they needed. One person said, "[Staff] know what they are doing, I feel sure of that at least."

We saw staff undertook training in aspects of care such as dementia awareness, fire safety, safeguarding, documentation, health and safety, basic life support, diabetes, first aid, and equality and diversity. Staff told

us the quality of training was good, one staff member commented, "If we want more, [the provider is] very good and will provide it." One staff member gave us an example of asking for more training around their dementia practise and this being provided.

Staff told us they felt supported by senior management. They told us it had been difficult with the management changes but felt positive about the appointment of the new manager. One staff member said, "I have supervision regularly, I get to talk about the work, residents, training and any updates I need, I feel okay, but it will be better with the new manager." Clinical staff told us they received their supervision with the clinical development nurse and found this useful. They said they were able to review people's clinical needs and plan and review their continuing professional development.

People's told us they were able to make decisions daily about what they wanted to eat, and that the chef always promoted healthy choices in the menu. One person said, "I choose what I eat daily." A second person said, "The food is okay, it's not chips and fried foods, it's food that our generation want to eat and it is all freshly cooked and healthy." However, other people gave mixed views about the food provided. One person said, "The food is great, that's one thing they are very good at." A second person however said, "I do not think much of the food. I eat it as little as possible. The food is bad. I have no dietary requirements, but I do eat kosher food. They are very bad at providing kosher food."

People's specific dietary needs were documented, but not always passed to the kitchen to ensure these needs were met. For example, one person was diabetic, and managed this through their diet. The chef was not aware of this person's needs. The chef took immediate action to review this person's eating and drinking support. One person's relative also told us, "[Person] cannot eat any fat. This is all in the care plan but the kitchen very rarely gives [Person] the correct diet as set out in the care plan." Following the chef's intervention and them having this information they were able to manage people's dietary needs. Where people's dietary needs had been identified, we saw appropriate guidance had been sought from dieticians and the kitchen were aware of these needs. Meals were prepared following this guidance and where food was pureed this still appeared appetising. We saw the chef was fully involved in mealtimes and spoke to people afterwards to ascertain their likes and dislikes. They were involved in reviewing those people at risk of weight loss, and took steps to provide high calorie meals and snacks to promote weight gain. Staff did not ensure that the kitchen team was provided with accurate information regarding people's dietary needs..

Mealtimes were calm and unhurried, with appropriate, frequent interaction between staff and people who used the service. People chose where they wanted to eat and they received the necessary support from staff to do this in an unhurried and sociable manner. People sat in their own social groups and were seen to be contentedly talking among themselves whilst enjoying their meal. People were supported to have sufficient quantities to drink and records reflected this

People were able to access support and treatment in a timely way and referrals were made quickly to appropriate health services when people's needs changed. One person said, "The GP visits regularly and If I need to see them then I just ask. We have the optician, dentist and chiropodist. I think if I needed anything then I would see the right person." A range of professionals supported people such as dieticians, GP's neurologists and mental health teams. However, staff did not always ensure people's appointments were well managed. For example, we found one person had not been well on the day of an appointment to the neurologist. Staff cancelled the appointment, but did not organise a further appointment, or inform the GP.

The premises were modern and purpose-built and homely. A recent refurbishment included appropriate adaptation and decoration for people who lived with dementia. There was ample space in people's bedrooms, as well as a large, open-plan communal spaces. People had access to en-suites in their room,

communal toilets and bathrooms were located throughout the units. All areas of the building were accessible for people who used wheelchairs or had mobility impairments. Outside the building, there were expansive landscaped gardens and entertainment areas.

Good

Is the service caring?

Our findings

Staff supported people with their dignity and they felt staff respected their individual needs. One person told us, "I have no concerns about that [Respecting my dignity] when they help me I have never been left feeling exposed or uncomfortable, I think they do their very best to keep me dignified." Staff were aware of the importance of maintaining people's privacy and dignity. Staff described to us how they ensured these needs were met by ensuring care was provided discreetly, encouraging people to self-care where possible, and ensuring doors were closed along with curtains and people were respectfully covered when assisting with personal care. We observed throughout the inspection interactions between staff and people was kind, considered and dignified. Where people required assistance with their personal care, staff were quick to identify this and discreetly took people to their rooms for assistance.

People and their relatives told us they were able to visit the home freely without restriction and were able to meet their visitor in private if needed. One person said, "My children work, so do my grandchildren so my visits are at very different times both day and night."

Staff maintained people's confidentiality and kept their records securely. We observed when staff spoke about a person's personal needs they did so quietly so they could not be overheard, or left the room for a private discussion. This helped to ensure people's confidential information was not inadvertently disclosed.
.
Staff responded in a compassionate and appropriate way when people experienced physical pain or emotional distress. For example, clinical staff were observed throughout the day to care for a person who was receiving palliative care. They ensured this person continued to receive sufficient pain relief to keep them comfortable and care staff ensured they spent time with this person to offer reassurance and support.

However, we were told by people and relatives that staff awareness of ensuring their dignity was met was not consistent. For example, one person's relative said, "[Family member] need to have their hearing aids switched on and correctly placed. This very rarely happens. They therefore cannot communicate at all without their hearing aids."

We spoke with one person in their room, and although we saw they were well dressed and presented we found the persons room gave off a malodour. The carpet was heavily stained and did not promote a dignified environment for this person. This persons room had undergone cleaning recently, however the aroma remained.

People told us they were supported to remain independent. One person said, "I do as much everyday as I can, I know one day I won't be able to so while I can I will wash, dress, and do as much as I can and they [Staff] don't stop me from doing that." Staff were aware of the importance of people remaining independent. We observed staff encouraging people to eat their meals, engage in activity and self-care to promote their independence and autonomy. Information was made available to people and their relatives about external organisations such as advocacy services that provided independent support about their care and where necessary, advocate for them.

People told us that staff were kind and caring. One person who used the service told us, "They're very nice. All the staff are kind to me." A second person said, "The staff here are very caring and not just doing a job." One staff member said, "I just want to put a smile on people's faces."

We saw care staff acting in kind, gentle and compassionate ways towards people. Staff spoke of people with kindness. Staff showed genuine concern for people's wellbeing in a caring and meaningful way. Staff were able to provide us with numerous examples of how they met people's needs in a caring and patient manner. For example, we observed staff offering support when a person was upset and anxious. They took the time to understand what was causing the persons anxiety and found ways to resolve their concerns. Where this person was refusing to eat their meal at the time, we saw that by the staff's patient interaction, gentle touch and reassurance this person then sat contentedly finishing their meal.

Requires Improvement

Is the service responsive?

Our findings

People told us they knew how to raise their concerns and formally make a complaint; however, they were not confident this would be dealt with. Due to the changes in managers at the home, complaints that had been raised were not responded to. One person's relative told us, "I made a complaint about the phone not being answered. I tried calling at different times and the phone was still not being answered even after my complaint and recognition that the phone should be answered after hours. The complaint took three months for the area manager to address. It makes our family reluctant to making complaints in the future. The process is broken and there is no effective complaints process that we would consider using."

We were told that when people or their relatives raised a concern with staff or management it was not investigated or responded to. For example, one person's relative raised a complaint following a visit to their relative on 7th August 2018, they emailed the manager in relation to issues with laundry, concerns regarding care and staffing issues. They followed up on their initial complaint on 21 August 2018 and again on 31 August 2018. On 5th September 2018 they telephoned the provider, who organised a response from the home suggesting a meeting on 11 September 2018 which the relative declined as they wanted a formal response in writing prior to a meeting. At the time of this inspection they had not heard anything from the manager, which was outside of the 28 days to respond as written in the complaints policy. This person contacted us after the inspection because their complaint had not been investigated. We asked the provider to respond which they subsequently did, however not at the time the complaint was raised with them. We also found that a number of other concerns or complaints had been not been managed following the provider's policies. As people's complaints were not responded to in a reasonable time frame, this has resulted in a breach of regulation 16 of the Health and Social Care Act 2008 [Regulated Activities] regulation 2014.

People's views about being able to contribute to planning their care and support varied. Some people and relatives felt able to develop and shape the care they received. One person said, "I regularly talk about what I want and how I want things done, I think they keep me informed and up to date. I know about my care plan, have seen it, signed it and am happy." However, other people and relatives felt they were not able to contribute. One person told us, "I do not know what a care plan is. I have not seen one and do not understand what you mean." A second person said, "Yes [They ask me about my care] but it makes no difference." The views of these people was further confirmed by relatives. For example, one person's relative said, "They do not listen. The care plan is not implemented." This meant that although people received care it was not based on their views or opinion and had been delivered in a task orientated manner.

Staff understood the importance of flexible and responsive care, based upon people's involvement and ongoing contribution to development of their care plan. However, this was not the view of the majority of people living in the home who told us care was not provided in this manner. Those care plans that had been developed were personalised and took into account the needs and wishes of people. However, the majority of people we spoke with were not aware of their care plan or how it had been developed. This is an area that requires improvement to ensure people are sufficiently involved in the development and review of their care and aware they can contribute to shaping how their care responds to their needs.

People gave a mixed response when asked how they are supported to follow their interests and take part in activities that are relevant and appropriate to them. One person said, "I enjoy the activity they put on, it makes the day go by and is nice to see other people." A second person said, "If you don't join in there is little to do."

People were provided with a weekly timetable of activities available both mornings and afternoon. In addition, social events were planned such as parties, trips out and celebrating special events. Although people were mostly satisfied with the range of communal activity we found that people who chose to not participate or who were cared for in bed were not supported in the same manner consistently.

Where people were able to mobilise and pursue their interests staff supported them. For example, one person who enjoyed gardening had been supported to plant shrubs and develop their own area of garden. However, for people in bed, they told us they were at times bored at isolated and did not feel part of the wider community. One person said, "I can't get down there to join in yet, but I am looking forward to when I can. It's lonely here with no-one to talk to much, other than when they give me my lunch or the care." One person's relative said, "Activity, yes [Person] watches TV. They do nothing other than let them watch TV. If we are not here they do not even check if the TV is switched on."

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. The manager had started working at the service two weeks prior to this inspection. Subsequent to the inspection they submitted an application to register as the manager of the home. Staff told us prior to the new manager starting they had not felt the service was well managed and that there had been a lack of stability. One staff member said, "The deputy has been amazing over the last few months, but we have just been left to get on with it, we weren't kept up to date with the changes and why they happened. [Manager] looks to be approachable, but time will tell."

People's views about the management of the service varied. One person said, "I think things are well managed, but I don't know the manager, I do not know if they are approachable because I have never spoken to them." A second person said, "The only thing that makes this place work is the kindness of the staff." One person's relative said, "They have now got [Manager] so hopefully things will improve but for the last six months it's been very poorly managed by a mixture of managers." Although the new manager took action during this inspection with staffing deployment and responding to call bells we found in the absence of a permanent manager, the provider had not ensured robust interim arrangements were in place to monitor and improve the quality of care people received.

Prior to this inspection in July 2018 we raised concerns with the operations' manager who was covering the vacant managers post. These concerns were related to low staffing numbers and people having to wait for a significant period of time for their call bell to be answered. In their response on 25 July 2018 they told us they were reviewing call bell responses and staffing levels. At this inspection, we found no actions had been taken to improve this issue, and people continued to wait for an unacceptable amount of time for their call bell to be responded to.

People and their relatives told us their views about the quality of care they received had not been sought. Although the manager held a meeting with people on the first day of our inspection, people told us they had not been provided with an opportunity to discuss the running of the home. Staff told us they had regular meetings, however people and their relatives gave a mixed response regarding being kept informed about developments in the home. One person's relative said, "There have been meetings in the past which have dried up, but I find if I need to know something then I just ask and they will tell me." A second person's relative said, "They have the newsletter, that can be useful I think, but I want to be able to talk to the manager and I don't even know who they are." The new manager had sent people a welcoming letter. This was to introduce themselves that week. This was to enable people and their relatives to get to know the manager and discuss any issues they may have.

A system of auditing and monitoring the care provided was in place but not effectively used. The manager did not have a service improvement plan or action plan they were working towards to develop the quality of care people received. The regional manager had completed a monthly audit of the service in August 2018 but was after we raised concerns. This audit did not address the issues regarding staffing or call bell response. They had identified that audits undertaken by the home management were not complete but did not define when these would be completed. When we inspected on 12 and 27 September 2018 these

remained outstanding. They had identified complaints remained outstanding, however these continued to be unresolved.

The provider had not routinely monitored and analysed trends emerging from incidents or accidents within the home. This had contributed to excessive pressures placed on care and nursing staff. Call bell analysis had not been reviewed to ensure people's needs were met in a timely manner. These among other areas had not been addressed until the appointment of the new manager, who took action following this inspection.

Statutory notifications of significant events had not consistently been submitted to CQC promptly. We found there had been delays in reporting incidents, injuries or safeguarding concerns both to CQC and the local authority safeguarding team. An effective system of monitoring the quality of care provided was not in place, this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe Care and Treatment Regulation 12 (1) (2) (a) (b) and (g) The registered person had not ensured people's needs were safely responded to when they summoned assistance. People did not receive their medicines in line with the prescribers instructions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Receiving and acting on complaints. Regulation 16 (1) (2) The registered person did not ensure those complaints raised with them were investigated and necessary and proportionate action. A system was not effectively operated to receive, record, handle and respond to complaints byin relation to the carrying on of the regulated activity.

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 Good Governance Regulation 17 1, 2 (a) and (b)

	Systems or processes established were not operated effectively to ensure regular monitoring of the quality and safety of care provided to people.

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 Staffing. Regulation 18 (1) Sufficient numbers of staff were not effectively deployed to support people when they required this.