HC-One Limited

Pytchley Court Nursing Home

Inspection report

5a Northampton Road
Brixworth
Northampton
Northamptonshire
NN6 9DX

Tel: 01604882979
Website: www.hc-one.co.uk/homes/pytchley-court/

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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**

Summary of findings

Overall summary

This inspection took place on 26 and 27 April 2018 and was unannounced. At the last inspection in July 2017 we rated the service as 'Requires Improvement' and found breaches with four Health and Social Care Act Regulations. These were in relation to obtaining consent, safe care and treatment, managing complaints and how the service was managed and monitored. At this inspection we found that improvements had been made in relation to obtaining people's consent and in managing complaints. However, we found on-going issues in relation to the delivery of safe care and treatment and in relation to the management of the service. We also identified further concerns in relation to staffing levels and the training and induction of staff into the service.

Pytchley Court Nursing Home 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. There were 35 people using the service at the time of our inspection.

The service is split over two floors and a condition of the registration is that there is a registered manager in post. There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There had been some instability with the leadership of the service prior to our inspection and this had an impact on the quality of care and treatment being delivered at the service and on staff morale. There had been a high turnover of managers at the service which had resulted in a lack of consistent oversight of people's health and care needs. There was a "Turnaround Manager" in the service at the time of our inspection who was at the service on a temporary basis whilst a newly appointed manager was receiving their induction.

There were insufficient suitably trained and competent staff working at the service to ensure people's safety. Staff were safely recruited, however, we found gaps in training and a lack of suitable staff induction. Some staff had started working in new posts without any induction or training.

People were not receiving safe care and treatment. We found that medicines were not always safely managed, that there was no consistent oversight in relation to people who were having their food and fluid monitored and that people had experienced delay in referrals to health professionals. The premises were not being safely managed and did not provide a suitable environment for people at all times.

People's consent was obtained prior to them receiving care and treatment. However, improvements were needed in relation to how people's capacity was assessed and decisions were made and documented in

their best interests.

People's privacy was not always respected at the service and there was limited evidence in people being involved in decisions about their care and treatment.

People had a choice of nutritious food and drink and people were supported to eat and drink when this was required. The service offered people a range of activities and took into account people's views and preferences.

People were cared for by staff who treated them with kindness. People were encouraged to remain as independent as possible.

Incidents and accidents were reported and appropriate action. Statutory notifications were issued as required by law and the service was displaying their rating 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 safe.

There were insufficient staff to deliver care and treatment to safely meet people's needs.

Care and treatment was not always delivered safely and the premises posed a risk to people using the service.

Medicines were not always safely managed and there were some gaps in the systems to ensure vulnerable people were protected from the risk of abuse.

People were protected from the risk of infection and there were systems in place to monitor and learn from incidents which took place at the service.

People we spoke with felt safe using the service and with the staff who delivered their care and treatment.

Staff were safely recruited.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not adequately trained and supported in their roles.

Although people's capacity was assessed at the service, decisions made on behalf of people who lacked capacity were not always documented.

People were supported to eat and drink and had a choice of nutritious food.

The premises were suitable designed for people, although they were not always being used appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Call bells and the telephone rang very loudly throughout the service during our inspection. This was an invasion on people's privacy.

People and their relatives were not always involved in care planning and decisions were not always made in consultation with people, their relatives or their representatives.

People were cared for by kind and caring staff who maintained their dignity and treated them with respect.

Is the service responsive?

Requires Improvement

The service was not responsive.

Not all complaints had been adequately responded to although improvements had been made in this area. People were not always sure who to approach with concerns and issues due to management changes at the service.

There was a delay in referrals to health professionals.

People's personal preferences were respected and acknowledged and people were able to spend their time in the way they chose and would enjoy.

People's wishes for the end of their lives were planned for.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no stable management structure in the home and there had been frequent changes in the home manager which had resulted in staff feeling uneasy about the future of the service.

The quality of the service was not being effectively monitored and the issues we picked up on the inspection had not been addressed by the provider.

Incidents and accidents were being monitored but insufficient action had been taken as a result of these.

The service was displaying their rating.

Pytchley Court Nursing 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

We inspected this service due to a number of concerns which had been received by the Commission in relation to the quality of the care and support being delivered at the service. These concerns had come in to the Commission from a number of sources.

We inspected the service on the 26 & 27 April 2018. The inspection was unannounced. The inspection team consisted of an inspector, an assistant inspector, a specialist advisor who was a nurse and two experts 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed 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.

During the visit we spoke with eight people who used the service and the relatives of ten people who used the service. We spoke with the area director for the service, the acting manager, the deputy manager, a maintenance staff member, the well-being co-ordinator, the head chef, three nurses, a nursing assistant and four staff who provide care and support to people at the service.

We looked at the care records of six people who used the service, medicines records, staff recruitment and

training records, as well as a range of records relating to the management and running of the service including audits carried out by the provider.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2017 we found that improvements were needed in how people's medicines were managed, how risks were planned for and in relation to staffing levels at the service. At this inspection, we found further issues with how medicines were managed and found that staffing levels continued to fail to be sufficient to meet people's needs. We also found concerns with the premises and some gaps in the systems in place to protect vulnerable people from the risk of abuse.

People were not being cared for and supported by sufficient numbers of adequately trained, skilled and competent staff at the time of the inspection. We found that staff were task focussed and lacked time to spend with people. On the first day of our inspection there was one nurse on duty and a nursing assistant for 20 nursing residents, many of whom had complex clinical needs. There were seven care and support staff on duty for a total of 35 people. One the second day of our inspection there were two RMN's on duty and seven care and support staff. We were told that the Deputy Manager was the Clinical Lead at the service, however, this member of staff had not been trained to take on this role. This staff member was not on duty on the first day of our inspection and so the temporary manager was acting as the Clinical Lead.

We observed people calling out for long periods of time and some people became distressed as a result. The call bells were ringing for long periods of time and people we spoke with and their relatives told us that there was not always enough staff to safely meet people's needs. One person told us, "They don't come really quickly and I'm kept waiting to go to the bathroom." One person's relative said, "She's safe in the day – I'm not worried about that. It's the nights that I worry about when she's had a couple of falls, so I wonder if there's staff lacking." Another relative we spoke with referred to their relative falling and attributed this to a lack of staff. They told us, "There seem to be plenty of staff when I visit and also at week-ends, but I don't know about the evenings. He had a fall at night, but since then they say that they have been checking up on him every hour."

There were a high number of falls that had taken place at the service and many of these falls had been unwitnessed. For example, in December 2017 we found that there had been 11 falls at the service and that eight of these had been unwitnessed. There were nine unwitnessed falls reported as incidents in January 2018, three in February and three in March. The reporting of these falls indicated that at times there were insufficient staff to safely meet people's needs and to adequately protect them from the risk of falling. One incident record from March 2018 recorded, "Whilst staff nurse was undertaking the medication round and staff were assisting people to leave the dining area, JH slipped from her wheelchair to the floor. She had attempted to move but cannot. Staff nurse could not get over to her in time." We found several records of people slipping from wheelchairs and falling unwitnessed by staff. As people were at risk of falling, we concluded that staffing levels meant that people were not being adequately protected from this risk as staff could not attend to people as and when they needed to.

During our inspection we observed one person who was in a state of distress calling "help me" for over 10 minutes. Staff had been into the person and advised that they would need to wait until they could come back. This person became increasingly distressed and extremely anxious. Another person who required

assistance with their meal was heard to be calling out for help from their bedroom and banging their cup for over 10 minutes before staff came to assist them.

We asked to see the dependency tool used which determined staffing levels at the service based on the needs of people who used the service. We were shown a template document used remotely and were told that people's dependency did not form part of the calculation of staffing numbers at the service. From our observations of staffing levels and people's needs, we concluded that there were insufficient staff working at the service to safely meet the clinical and care needs of the people using it.

We looked at minutes from a meeting with people's families on 20 March 2018 where relatives expressed concern about staffing levels over the weekend. The meeting notes stated, "Concerns from relatives that the weekends always seem short staff and that they never see staff in the communal areas. The amount of agency staff at weekends is also high." Although the temporary home manager was on call over the weekends, we found that there was no appropriate management in the service. The temporary manager lived several hundred miles away and it would not have been possible for them to attend the service at short notice. We raised this with the provider who told us that this would be looked at immediately. However, we remained concerned about the safety of people over the weekends.

The provider failed to ensure there were adequate staff within the service to keep people safe. The above evidence is a breach of Regulation 18 (1) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

People had not always had timely referrals to health professionals and we found that here had been a two week delay in relation to one person using the service who was identified as having a pressure ulcer. We spoke with a district nurse visiting at the time of our inspection and they told us that, "Residents developing wounds would benefit from earlier referrals." We found that people did not always receive safe care and treatment due to a delay in the recognition and referrals in people's conditions.

There were areas of concern in relation to how medicines were managed at the service. This was not always done safely. For example, one person using the service had Parkinson's disease and was taking time critical medication. We found that this medication had not been given to this person as they had been asleep. This is not an acceptable reason not to administer this medication as its therapeutic effects depend on its regular administration. On two further occasions the person had refused this medication. No action had been taken to address these omissions in this medicine. There were insufficient systems in place to ensure that people received their medicines prior to eating and that staff lacked clear guidance in relation to this.

Some people using the service were receiving their medications via a trans-dermal patch. There was a rotation chart in place showing the administration site (rotating the site is important to avoid sensitivity/irritations developing). However, this was not always completed. The removal of the previous patch to avoid the risk of overdose was not recorded and there was no record of daily checks that the patch was still in situ. The daily checks are important as patches are prone to falling off or accidentally being removed by people and where there are barriers to communication residents could experience unnecessary pain. In these cases we were not able to ascertain whether this pain relief medication was being administered or managed safely as there was a lack of recording in relation to this.

The MAR charts of people prescribed topical creams were not being signed. A number of creams prescribed are to create a barrier and are used to prevent the development of skin break down. Therefore this is a prescribed preventative intervention both on the MAR chart and in the care plan for pressure ulcer prevention for residents identified as at risk. The MAR was not signed to evidence that the intervention has

been carried out.

Some people using the service were on a food and fluid chart to monitor their daily intake. People on a fluid chart did not always have the daily target indicated at the top of their chart. The fluid charts for the previous day of three people we looked at showed that they had had less than 50% of the daily recommended intake of 1500mls per day. We found no evidence that this had been followed up. Two people did not have their fluid output recorded. This was important as these people had catheters in situ and the output can be an early indicator of retention or infection. The charts confirming the weekly catheter bag changes had many gaps. These gaps meant that we were not assured that catheter care was being safely managed at the service.

During our inspection we found the premises to be cold. On the second day of our inspection people told us they were cold. People were seen to be rubbing their hands together to keep warm and many people were wrapped in blankets. People were seen to be wrapped in blankets during the lunch-time meal as they were so cold. When we raised this with the maintenance member of staff on duty, we were told that there was no immediate source of heat within the service. Due to a heating system based on storage heaters there was no way of heating the building to provide people with the immediate heat they needed. The system had been switched off the week prior to our inspection due to unseasonably warm weather. However, due to a change in the weather, the service had become very cold with no immediate sources of heat available throughout the home. The premises did not have a suitable and safe system to ensure people were kept warm and comfortable. We found bedrooms and communal areas to be unacceptably cold.

A number of hoists and hairdressing equipment were being stored in the communal bathrooms within the service. When we asked why these were stored in these areas of the home we were told that there was no storage space to keep equipment. Storing equipment like this posed a safety risk to people as well as limiting the use of these communal bathrooms.

The provider failed to ensure that people received safe care and treatment. The above evidence is a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at safeguarding incidents which had taken place at the service and found that these had been appropriately documented and that action had been taken as a result of these. The relevant agencies had been notified when an allegation of abuse occurred at the service and steps taken to protect people where management had oversight of these. We did, however, identify some gaps in staff training in relation to protecting vulnerable people from abuse and some of the staff we spoke with were not always clear on how to report any allegations. Further improvements were needed in the systems to ensure that all staff working at the service understood how to recognise and report any allegations of abuse.

People were protected from the risk of infection as the provider had infection control procedures that staff followed. We found the home to be clean and hygienic at the time of our inspection and staff described following safe infection control procedures when delivering care and support to people. Relevant staff training in infection control and food hygiene took place at the service.

People told us they felt safe at the service and with the staff who delivered their care and support. One person said, "I don't know what makes me feel safe I just feel safe here and secure." We found that there were systems in place to learn from incidents which took place at the service as the provider had a tracking system to analyse incidents.

The provider followed safe staff recruitment procedures. Records confirmed that Disclosure and Barring Service (DBS) checks were completed and references obtained from previous employers. The provider had taken appropriate action to ensure staff at the service were suitable to provide care to people.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that the service was failing to adequately train staff for their roles. At this inspection we found that this remained the case. We spoke with staff who told us that they had not received training in key areas of safe care delivery. For example, two staff members we spoke with had not done any safeguarding training prior to starting to work with vulnerable people. One of these staff members was very new to the service. These staff members were not clear on what to do should they suspect someone was being abused.

We spoke with staff about their support and training at the service and three staff members told us that they felt improvements could be made. One staff member said, "The induction is not good enough and I think they need to change the training as well. In other jobs you have two weeks training. You don't know anything when you start here." Another staff member said, "I feel supported but because of the time it has taken to give me a job description and management training I'm not so sure."

Staff had started working in new positions in the home with little training and support. There were recruitment challenges at the service and some of the staff had come from a local agency. However, the required training had not always been delivered to ensure people's safety prior to new staff members starting work. Equally, where staff had been promoted into management positions, their training and support had not been provided in a timely manner to enable them to do this safely. We raised this with the provider who undertook to address these shortfalls following our inspection.

We spoke with a visiting professional during our inspection who told us that they felt there was often a delay in timely referrals by the service. They went on to say that, "Nurses don't always have the necessary competencies for the role, we had an urgent referral for a resident who needed a supra-pubic inserting, the nurse should have that competency." They told us that they felt that staff in the home did not always know what category of resident they were being asked to see and added, "This has resulted in nursing residents being treated by the district nurses in error." This raised concern about staff training and competence at the service.

We looked at the staff training and support records at the service and found shortfalls in staff training and supervisions. When we raised this we were told that this had been due to management changes within the service. Training records provided to us by the management at the service showed gaps in staff training in relation to safeguarding vulnerable people from the risk of abuse. We found that 18% of staff's training in this area was late or overdue. We also found training gaps in relation to Falls Awareness. 20% of staff had not received up-to-date training in this area. We found that falls were a frequent occurrence at the service. Training records also showed that 40% of nursing staff's competency checks in relation to the safe administration of medicines were overdue. We found issues with how medicines were being managed at the service.

Supervision records provided to us on which were dated 26 April 2018 showed that 14 staff members were overdue a supervision and we were told by one staff member during the inspection that this was due to the

management changes within the service. The provider had not taken steps to rectify this. Some staff we spoke with did not feel supported in their roles and were uneasy about the management changes at the service. Several staff members described being concerned about the future of the service due to the constant changes in management which had resulted in a lack of staff support.

The provider failed to ensure that staff were adequately trained supervised and experience to work at the service. The above evidence is a breach of Regulation 18 (2) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

At our last inspection we found that the provider was failing to meet the legal requirements of 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 less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People had not always had best interest decisions documented in relation to certain aspects of their care and treatment. For example, having a health intervention such as the dentist and in relation to decisions made about how their care and treatment was planned. We raised this with the manager at the service who told us that this would be looked at following our inspection. There was no consistent management oversight to ensure that these decisions were appropriately made and documented due to the changes in management which had occurred at the service.

The provider had made suitable DoLS applications to the relevant authorities. The provider and staff understood their roles in assessing people's capacity to make decisions. People told us they were asked for their consent, where this was possible, prior to care and treatment being delivered to them.

People were given a choice of nutritious food and people had access to drinks throughout the day. However, we found that some people who required nutritional monitoring and who were on a food and fluid charts were not always being monitored fully. Food and fluid charts were not always totalled to ensure people got what they needed and although amounts were recorded, there were occasions when people had significantly less than their target amounts.

One person who was not eating and drinking very much at all had been identified as at risk by the service and we saw that measures had been put in place to monitor and encourage this person as much as possible. People we spoke with described having a choice in what they had to eat and drink and meal-times were a pleasant experience for people. We found that people were supported to eat and drink where this was needed. We observed people being served food which looked appealing and nutritious and people we spoke with and their relatives were all positive about the food and drink provided. One person who used the service told us, "Oh yes, they just ask what I would like. They tell me what is on the menu. They come just now and asked if I would like beef or lamb. I chose lamb. Lamb and mint is nice." Another person said, "I get four meals a day which is more than I used to. I've put on 1½ stone since I've been here."

There were some delays in referrals to health professionals. Records we looked at confirmed that there had been a four week delay in relation to one person with a pressure area. We found that people's health was not always effectively monitored on an on-going basis.

The premises provided suitable accommodation for people, however, we found that some communal bathrooms were being used to store hairdressing equipment and hoists. This restricted the use of these communal bathrooms and posed a risk to people. People could move easily around the service. We found there was a pleasant garden area which was maintained so that people could use it when they wished to. Communal lounges were comfortable and inviting for people.

Requires Improvement

Is the service caring?

Our findings

During our inspection we found that the telephone and call bells rang very loudly throughout the service during the day. We raised this with the manager at the home who during the course of our inspection had a pager system for staff re-implemented so that people were not listening to such a loud call bell system. The telephone continued to ring very loudly throughout the service. We found evidence that a relative had complained that the call bell system was far too loud and that it was disturbing their relative in their room. The management of the service had not recognised that this was inappropriate for people who were living in their own home and for some people living with dementia may cause added stress.

People we spoke with did not feel they were involved in their care plans and we found instances where people's families had not been involved in key decisions about their care and treatment. For example, one person's relative had raised a complaint as a Deprivation of Liberty Safeguard had been applied for by the service and the family and person's representative had not been informed. Another person's family had not been informed about GP involvement due to them being unwell. One person said, "I know there's a care plan, but I'm not exactly involved in it." Another person's relative told us, "Reviews are not being done with family members as often as they should be." We looked at care plans for people and found little evidence of people's involvement in these.

There were systems in place to enable people and their relatives to express their views about how the service was run. Regular meetings were available to people with the management of the home and we saw from the records of these meetings that people's views were listened to and that some had been acted upon. There was evidence that action had been taken to specific feedback which demonstrated how people had been able to raise concerns.

We observed staff treating people with kindness and respect during our inspection. Staff reassured people whilst moving them and staff encouraged people to interact with people and to carry out activities they may have enjoyed. Staff supported people during meal-times in communal areas and people appeared to be comfortable with the staff who supported them. We asked people about whether staff were kind to them and people told us that they were. One person told us, "They are always polite and respectful."

Steps were taken to ensure people's dignity was maintained. People were encouraged to take care of themselves in ways they would like. For example, a hairdresser visited during our inspection and people were given the opportunity to sit in a pleasant hairdressing salon and have their hair done. Many people using the service clearly enjoyed this experience which was important to them. Thought was given as to how people spent their time and there was a lively atmosphere within the home throughout our inspection.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found that complaints had not always been adequately responded to by management at the service. At this inspection we found that the majority of complaints had been dealt with in a timely manner and that most complaints had been fully responded to within a reasonable time period. We did find one instance of a complaint which had no written response. We raised this with the manager at the home who was unable to find any response to the complaint. As 12 of the complaints we looked at had been fully responded to we concluded that improvements had been made in this area. The complainant for whom no response was found was no longer using the service.

People could raise concerns and issues and they told us that they felt these would be responded to. Issues had been addressed by the temporary home manager and records we looked at provided evidence that action had been taken in most cases. People told us that they would be comfortable raising any issues should they need to. One person's relative told us, "Yes I have confidence in them. I have spoken to them during the last three days I've been as he is very poorly at the moment. They had been very responsive to me and warm. The doctors been a couple of times during the past few days as the staff called him out." A person using the service said, "I would see the manager but the issue is the constant stream of managers." As there had been instability with the management team, we found that people were not always confident about who to approach. However, when the temporary manager was made aware of issues, we found that these were addressed appropriately.

The service was not always responsive to people's needs due to a delay in referrals to health professionals. We spoke with a visiting health professional during our inspection who told us that they thought people using the service would benefit from earlier referrals. One person, for example, had a pressure ulcer which was identified on 2 February 2018 but not referred to a Tissue Viability Nurse until 28 February 2018. The person the visiting professional was visiting on the first day of our inspection had leg ulcers and, again, the professional we spoke with felt that they too would have benefitted from an earlier referral by the service.

Peoples' individual needs and preferences were reflected in the care records we looked and staff we spoke with knew people well. People told us that they were given choices in how they spent their time and what they had to eat. During our inspection we observed staff giving people options and encouraging them to do the things they knew they enjoyed or were able to in order to maintain their independence as much as possible. The majority of people were out of bed and there was a lively atmosphere within the service.

One staff member told us about a "Getting to Know You" booklet which had been introduced in order to make care planning and delivery more personalised. These were in place in people's care records and designed to enable staff to sit and talk to people about their life histories and their personal preferences.

There were activities made available to people should they wish to participate in them. We observed people engaged in activities and we spoke with the well-being co-ordinator at the service who told us that things had recently improved in this area at the service. They described plans being in place to celebrate the upcoming royal wedding and a singer came into the service during our inspection which people seemed to

very much enjoy. The activities were led by people who used the service who were able to suggest things that they enjoyed, such as gardening.

Where appropriate, people's wishes for the end of their life had been considered and planned for. We found evidence of this in care records we looked at. During our inspection someone using the service had passed away. This was managed sensitively and carefully by the management and staff at the service.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016. It makes it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager in post. 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. There had been some instability with the management team at the service and we were told during our inspection that the previous manager had not been suitable for the role and that they had left. The manager prior to this one had left the service abruptly and so the home had a "Turnaround Manager" in post who had worked at the service before.

There had been some significant instability with the management team at Pytchley Court over the months leading up to our inspection and that this had resulted in some unrest for staff working at the service, service users and their relatives. There had been no consistent management oversight and this had resulted in a lack of effective monitoring of both the clinical care and of the support staff.

Staff we spoke with all referred to the changes in management and one staff member described feeling very uneasy following some difficulties they had experienced with the previous manager who had left the home in January 2018. We found a culture of mistrust and unease from staff in terms of the future of the service and any new, incoming manager due to the changes which had occurred at the service and the instability this has caused. Although the Turnaround Manager was working hard to bring staff together, staff were unsure about the future of the service. One staff member said, "Due to the management issues we've had it's been very difficult here. It's daunting." Another staff member told us, "It's quite traumatic for the staff. Everything's up in the air."

We discussed the issue of a number of managers not remaining in post at the service with the "Turnaround Manager" who was managing the service at the time of our inspection. They told us that more support would be given to the newly appointed manager who was very new in post when we inspected the service and who was working off-site. We expressed concern with the area director that measures needed to be taken to give support to the newly appointed manager so that they felt able to take the service forward.

There were gaps in relation to staff supervisions and staff competency checks. When we raised these we were told that these were attributable to a lack of management oversight. Staff had started working at the service with little induction and training and some of the recruitment files we looked at contained gaps in employment histories.

A deputy manager had been appointed but that no induction or training had been provided in relation to this role. This was recognised by the provider who explained that this appointment had been made quickly and that the induction and training had yet to happen. We found that the management structure had not been effectively implemented and that this had an impact on the effectiveness of the clinical care at the service. Although the Turnaround Manager, who was a registered nurse, was at the service from Monday to Friday, we found that there were occasions when there was a lack of clinical leadership in the home.

The premises were not being adequately maintained and assessed for risks to people who used the service. We found the premises to be cold and found equipment stored in communal bathrooms. These risks had not been recognised or addressed.

There was no dependency tool used by the provider to determine staffing levels and we found that staff numbers were not adequate to meet the needs and complexities of people who used the service. Call bells were not monitored to assess how quickly these were responded to and people and their relatives told us they had to wait for care and support. We observed people calling out for long periods of time and that clinical and support staff were very busy in their roles. This had not been recognised by the provider and was not being monitored on an on-going basis. One staff member told us, "It's difficult. You don't want to rush them if you're putting people to bed."

There was a delay in referrals to health professionals which may have put people at risk. There was a lack of clinical oversight due to the demands of the clinical staff working at the service and the lack of an effective clinical lead at the service at all times to oversee the care and treatment. Incidents which took place at the service were recorded and acted upon as required by law and to protect people using the service. We looked through the incident and accident records and found that the relevant agencies had been notified and that action had been taken by the management. The provider was monitoring accidents and incidents. However, we did find a high number of unwitnessed falls which we attributed to inadequate staffing levels. This had not been recognised by the provider.

The provider failed to ensure there was adequate management oversight at the service to monitor the quality of care and treatment being delivered. The above evidence is a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The latest CQC inspection report rating was on display at the service and on the provider website. The display of the rating is a legal requirement, to inform people, those seeking information about the service and visitors of our judgments.

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 Medicines were not being safely managed. Referral to health professionals were not being made in a timely manner and the premises was not safe and suitable for people.

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 There was instability with the leadership at the service which had resulted in a lack of effective monitoring of service. This included a lack of oversight in terms of staff performance, training and induction, the premises and the care and treatment being delivered at the service.

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 There were insufficient staff to safely meet people's needs. There were gaps in staff training and induction which meant that staff lacked the skills and competence to safely carry out their roles.