Broadoak Group of Care Homes

South Collingham Hall

Inspection report

Newark Road
Collingham
Newark
Nottinghamshire
NG23 7LE

Tel: 01636892308

Date of inspection visit:
04 October 2016

Date of publication:
16 November 2016

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 4 October 2016 and was unannounced. South Collingham Hall provides accommodation and personal care for up to 33 people with and without dementia. On the day of our inspection 23 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At our inspection in January 2016 we asked the provider to take action to make improvements in respect of the cleanliness of the building and maintaining a safe environment. During this inspection we found that only limited improvements had been made. A legionella risk assessment of the water supply at South Collingham Hall had been carried out. However, not all of the recommendations that had been made had been implemented in a timely way. Steps had not been taken to ensure a clean environment was maintained in order to reduce the risk of infection.

People were left exposed to avoidable risks because steps had not been taken to assess and mitigate risks to people's health and safety. The building and equipment used was not always fit for purpose. There were not sufficient numbers of staff employed or deployed to meet people's needs in a timely way.

Staff understood their responsibility to protect people from the risk of abuse, although not all staff had received safeguarding training. People received their medicines when they needed them and medicines were stored and recorded appropriately.

Staff had not been provided with all of training required to care for people effectively. Staff told us they received supervision and felt supported. People's rights under the Mental Capacity Act (2005) were not always upheld. Relevant applications to deprive people of their liberty had not always been made.

People had access to sufficient quantities of food and drink and told us they enjoyed the food. However, support to eat and drink was not provided in a timely way. People had access to a range of healthcare professionals, but guidance provided was not always followed in practice.

People, or their representatives, were not routinely involved in planning and reviewing their care. Staff endeavoured to respect the day to day decisions people made but were not always able to accommodate their wishes. Staff supported people in a caring manner and had developed positive relationships with people. People were treated with dignity and respect by staff.

Person-centred care was not always provided and people's care plans were often out of date or contained incorrect information. Staff were aware of people's care needs and tried to provide activities and

stimulation. However, no activities were provided on the day of our inspection. People told us they would feel comfortable making a complaint and knew how to do so.

At our inspection in January 2016 we asked the provider to take action to make improvements in respect of the systems used to monitor the quality of the service and to obtain and act on people's feedback. During this inspection we found that sufficient improvements had not been made.

The quality assurance systems in place were not sufficiently robust in detecting issues of concern and bringing about improvements. There were limited opportunities available for people to provide their feedback about the quality of the service. There was an open and transparent culture at the home although formal staff meetings were not held routinely. Adequate resources had not been provided towards the upkeep of the building and to ensure good quality care could be provided.

There were several breaches of regulations and you can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's health and safety were not always assessed or well managed. People were left exposed to avoidable risks relating to the maintenance of the building and equipment.

There were not sufficient staff employed or deployed to meet people's needs.

People were cared for in an environment that could not be effectively cleaned.

Staff understood their role in protecting people from abuse but had not received the required training.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for by staff who had not received all of the appropriate training to carry out their role. Staff told us they received supervision and felt supported.

People's rights under the Mental Capacity Act (2005) were not always upheld.

People had access to sufficient food and drink although staff struggled to provide assistance in a timely manner.

People had access to healthcare professionals when required, although guidance was not always followed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not routinely involved in their care planning and making decisions about their care.

Staff cared for people in a compassionate manner and had developed positive relationships with people who used the service.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person-centred care and their care plans were not kept up to date.

People felt able to complain and knew how to do so.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance systems were not robust in detecting issues and bringing about improvements.

There were limited opportunities for people to provide their opinion about the quality of the service.

Sufficient resources had not been provided to ensure staff could provide good quality care.

There was an open and transparent culture in the home.

South Collingham Hall

Detailed findings

Background to this inspection

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

This inspection took place on 4 October 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of 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. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection we spoke with four people who were using the service, six relatives, two members of care staff, the cook, the administrator and the deputy manager. We spoke with three healthcare professionals and looked at the care plans for six people as well as any associated daily records. We also looked at a range of records relating to the running of the service such as medicines administration records and training records.

Requires Improvement

Is the service safe?

Our findings

At our inspection in January 2016 we found that people had been left exposed to the avoidable risk of contracting legionella from the water supply. The provider submitted an action plan detailing the improvements they planned to make. During this inspection we found that a legionella risk assessment had been carried out. The contractor had made numerous recommendations for remedial works, however these had not all been carried out within the timescales recommended by the contractor, this left people at risk of contracting legionella. The provider told us that the remaining works would be carried out in the weeks following our inspection.

The local fire service had visited South Collingham Hall in the months prior to our inspection and requested that improvements be made. We saw that the required improvements had not all been implemented as required by the fire service. Personal emergency evacuation plans were in place for each person, however some of these were out of date. For example, the plan for one person stated that they could walk with some support from staff. However, we observed and staff told us that the person could no longer walk. There was limited signage around the building, meaning that emergency service personnel could find the building difficult to navigate in an emergency situation. This put people at continued risk of harm in the event of a fire.

The building was not maintained to a safe standard. Several areas of the building required work to bring them up to a more satisfactory standard. For example, there was evidence of possible damp in the corner of a lounge. Wallpaper was peeling from the walls in several areas and some carpets were thin and stained. A large number of floorboards creaked loudly when walked on which would cause disturbance to people when trying to sleep. One person spent the majority of their time in their bed and relied upon staff for care and support and we saw that their call bell was broken. Staff checked on the person regularly throughout the day, however should they have needed assistance in between checks, they had to shout for help. The day of our inspection was warm and the sun was shining in through windows on one side of the home. Some windows could not be opened to allow fresh air in and some windows could not be fully covered by a curtain or blind. In addition, the heating was on meaning that it was uncomfortably hot inside the home. The ground floor radiators had not been covered which left people exposed to the risk of sustaining a burn injury.

Risks associated with the condition of the building meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and safety had not always been appropriately assessed and action was not always taken to reduce risks. The care plans we looked at contained a series of assessments of risks such as the risk of falling or developing a pressure ulcer. Some of the risk assessments had not been reviewed for between 12-24 months despite people being at risk of harm. For example, the risk of one person developing a pressure ulcer had not been assessed for 18 months, despite them previously being noted as being at very high risk. There was no guidance in the person's care plan about how the risk could be reduced. Whilst staff were providing support it was inconsistent and unclear what support the person needed. Another person

had been recently assessed as being at very high risk of developing a pressure ulcer. However, staff were not repositioning them at the required frequency and their pressure relieving mattress was set incorrectly. Staff had noted that the person's skin had recently broken down, this meant that not all steps had been taken to reduce the risks to this person. The staff we spoke with told us they were aware of such risks but were not always able to take the required action, such as assisting people to regularly change their position.

During our visit we observed that staff did not always use appropriate techniques when supporting people to change their position. For example, on one occasion a staff member assisted a person to change their position in bed by hand rather than calling for assistance and using the hoist. This put the person and staff at risk of harm. At the time of our visit there were only two hoist slings available for general use across the home, which were both the same size. This meant that some people may be put at risk of injury if using an incorrectly sized sling. The deputy manager told us that different sized slings were on order to be delivered shortly following the inspection.

Steps had not been taken to assess and mitigate risks to people's health and safety which meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us that they felt there were enough staff to meet their needs. One person told us they felt staff would respond quickly if they pressed their bedroom call bell for assistance. The relatives we spoke with provided mixed feedback about the staffing levels at the home. One relative said, "I think if they had any more they would be over loaded." Another relative commented that they felt there were sufficient staff available, however they were not always deployed effectively. We were also told by another relative that they felt staffing levels had not changed in response to an increase in the dependency levels of people living at South Collingham Hall.

During our visit we observed that there were not sufficient staff employed or deployed to meet people's needs. There were many occasions when staff were not able to provide the care people needed in a timely way due to being busy elsewhere in the home. For example, at lunch time there was only one member of staff available in the dining area to support 12 people. Other staff were busy assisting people into the dining room or providing one to one support to people in other areas of the home. The lunch period lasted for nearly three hours because there were not enough staff to assist people. We entered the kitchen one hour after lunch had started and saw the cook was plating up meals for people. We were told that these people had not yet had lunch because staff had not had the time to sit and assist them to eat. We also saw that staff did not always provide pressure relief or take people to use the toilet in a timely way because they were busy elsewhere.

The provider had not carried out an assessment of the numbers of staff required to meet people's needs either during the day or at night. The deputy manager told us that two members of care staff had recently left and they had not been able to recruit replacements due to the home's rural location. This had meant that there were not sufficient staff employed to be able to allocate enough staff on the rota each day. The staff we spoke with provided mixed feedback about whether there were sufficient staff to meet people's needs. It was acknowledged that staff had not always been able to meet people's needs on the day of our inspection.

There were not sufficient numbers of suitable staff employed or deployed which meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in January 2016 we found that the standard of cleanliness across the service left people exposed to the risk of infection. The provider submitted an action plan detailing the improvements they

planned to make. During this inspection we found that action had not been taken to make improvements to the condition of the building and people remained exposed to the risk of infection.

The condition of the building meant that some areas could not be adequately cleaned. For example, there were several areas that had exposed floor boards such as a sluice room. Wooden floors can't be effectively cleaned and this meant the risk of infection was increased in these areas. Several carpets in the upper floors were stained and not able to be effectively cleaned. One bathroom was out of use, however it was not secured to prevent people accessing it. The bath contained green mould where water had been dripping onto it. This meant that people were unnecessarily exposed to the risk of infection.

A recent infection control audit carried out by another agency had identified numerous areas of concern and these had not all been acted upon. For example, several mattresses had been identified as needing to be replaced, but these were still in situ at the time of our visit. The deputy manager told us that they were aware of the need to replace some mattresses and identified these during our visit. A cleaning schedule was in place, however this was not always completed to indicate what cleaning had been completed. Some equipment, such as the hoist and wheelchairs, were not included on the cleaning schedule and these were observed to be dirty. In addition, the procedure to follow in the event of an outbreak of an infection was not understood by all staff.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with felt that the general standard of cleanliness was acceptable. During our visit the cleaner ensured that communal areas, bedrooms and bathrooms were cleaned. The provider had employed an additional cleaner since our previous inspection which increased the amount of time available for cleaning and care staff were responsible for cleaning outside of the cleaner's working hours.

The people we spoke with told us they felt safe at the care home. One person said they felt, "Reasonably safe." Another person told us they felt comfortable raising any safety concerns and told us, "I should complain to a member of staff straight away." The majority of the relatives we spoke with also told us they felt people were protected from harm, one relative commented, "Oh yes. They've got staff on duty on all the time, there's locks on the front door, very good." Another relative said, "I would say that [my relative] is safe."

During our inspection we saw that there was a calm and relaxed atmosphere during the morning and people were comfortable in the presence of staff. However, during the afternoon some people became distressed and agitated. The staff we spoke with had a good knowledge of their responsibilities to keep people safe and how they would report any concerns. However, they were not always able to respond quickly enough to prevent people becoming more distressed. One person regularly called out to other people in the home asking them to leave. When staff sat with the person they became calmer, however staff were not always able to do this. Two people had a verbal disagreement regarding access through a doorway. Staff attended and were able to resolve the disagreement, however they had not been able to prevent it happening.

The provider had not ensured that all staff were developed and trained to understand their role in safeguarding people because appropriate training was not provided for all staff. Despite this, staff had a good understanding of how they could act to protect people and felt that the registered manager did act on any information of concern they reported.

The people we spoke with told us that they were satisfied with the way in which staff managed their medicines. One person said, "I get that regularly (medicine). They bring it round and I take it." The relatives

we spoke with also provided positive feedback regarding the management of medicines. During our visit we observed the deputy manager administering people's medicines and saw that they followed safe procedures and ensured people had the time they needed to take all of their medicines.

Medicines were stored securely in a trolley which was locked when it was not in use. Controlled drugs were also securely stored in a separate area. Controlled drugs are a group of medicines which have the potential to be abused and are subject to more stringent legislation regarding their storage. People could be assured that their medicines would be ordered in a timely manner as there was an effective system in place for the ordering of medicines to ensure people received these when required. The staff we spoke with had a good knowledge of safe practice regarding handling and administering people's medicines. Staff told us they received the support they required to manage people's medicines safely and this included regular training and competency assessments.

Requires Improvement

Is the service effective?

Our findings

The people we spoke with felt that staff were trained and provided effective care. One person commented, "Oh yes, everybody's very competent." The relatives we spoke with also felt that staff received the training required to carry out their duties effectively. One relative said, "They have group sessions and the staff are trained. They're given a lot of assistance to start with and given responsibility in a supervised way. I have seen them having discussion groups in the dining room for new staff."

People were supported by staff who had not always been given the training needed to provide effective care. Whilst some training had been provided since our previous inspection in areas such as end of life care, there remained many areas where staff had not received training. For example, no staff had been provided with training in relation to fire safety or first aid. In addition, not all staff had received training in safe moving and handling techniques or caring for people with dementia. During our visit we observed that staff did not always use safe techniques when assisting people to change their position. The staff we spoke with told us that they had not always been provided with the training needed at South Collingham Hall, although some staff had received relevant training elsewhere.

The lack of training for staff meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with told us they were supported by the registered manager and felt able to approach them for support. Staff told us that they received regular supervision and occasional observation of their practice, although we were not provided with records to verify when staff had received supervision. New staff received an induction and were able to shadow more experienced staff before working unsupervised. This gave new staff the chance to get to know people's needs and the working practice of the home before they started to provide care for people.

Where people lacked the capacity to make a decision the provider had not always followed the principles 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 least restrictive as possible. Where people may have lacked the capacity to make certain decisions, assessments of their capacity had not always been carried out. When assessments were carried out, some were correctly completed and indicated the decision that had been made in the person's best interests. However, other assessments did not clearly indicate the decision that needed to be made.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that some people were being deprived of their liberty without the necessary application

to the local authority having been made. For example, two people regularly asked to leave the home and became distressed when they were told they couldn't leave. One person's care plan advised staff to take the person for a walk to reduce this distress, this did not happen on the day of our inspection. Records suggested that the person was not consistently supported to take a walk. No application had been made to authorise this restriction on the person.

People's rights under the MCA were not upheld which was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit staff were observed to ask people for consent before providing any care and support. The people we spoke with confirmed that staff did ask them for their consent before they provided them with any personal care and support. The staff we spoke with were able to describe the principles of the MCA and why it was important to support people to make their own decisions where possible.

People we spoke with were generally complimentary about the quality and quantity of food and drink provided. One person said, "It's satisfactory, I can't say that it's Michelin star food." Another person said, "The food's good, as much as you want. It's usually a set meal." Another person commented that alternatives would be provided if they didn't like the food on offer that day. The relatives we spoke with were also complimentary about the food. One relative said, "The food is excellent. [My relative] eats up everything they are given." Another relative told us, "The food is perfect. [My relative] likes the food. They can't wait to get into dinner."

During our inspection people did not always receive the support they required to eat their meals. A significant number of people required support or prompting to eat their meals and staff were unable to provide this support. This resulted in some people becoming agitated at the delay in receiving their meal. Other people started to get up and leave the dining area and some meals were not fully consumed. Due to these delays lunchtime did not finish until about 3:30pm and then tea was provided only an hour later. This meant there was then a long gap between tea and people receiving their breakfast the next day which would increase the risk of them becoming hungry during the night.

People were provided with alternative choices where required and specialised diets were catered for, such as soft diets and low sugar alternatives. However, the kitchen staff did not have access to written information about people's dietary requirements. This meant there was a risk that inappropriate food could be provided. The staff we spoke with told us people had access to sufficient food and drink as well as snacks in between meals.

People told us that they had access to various healthcare professionals. One person told us that staff arranged for them to see their doctor when required. Another person told us, "I'd ask and they'd do it (arrange an appointment)." The relatives we spoke with were also assured that staff took action to contact healthcare professionals when it was necessary. One relative said, "They (staff) would ring up. I think the doctor comes regularly."

People were supported by staff to access healthcare services such as their doctor and the district nursing team. More specialist services were also contacted such as the continence advisory service and tissue viability service. However, guidance provided by healthcare professionals was not always embedded into the care provided. For example, a behavioural support plan had been provided to support staff in caring for one person in a more effective way. This had not been incorporated into their care plan and wasn't being used in practice. This meant that the person was not being effectively supported to lead a more fulfilling life because staff were not following recommended guidance. The staff we spoke with told us they arranged

appointments for people and that they wouldn't hesitate to contact the appropriate service.

Requires Improvement

Is the service caring?

Our findings

People, or their representatives, were not routinely offered the chance to be involved in planning their own care. The people and relatives we spoke with had not been involved in reviews of their care plans, although two relatives commented that they were consulted about individual decisions that needed to be made. The care plans we viewed had not always been signed by the person using the service or their representative. There were monthly review documents in each of the care plans we viewed, however these did not demonstrate that people had been consulted about any changes that may be required to their care.

People were involved in making day to day choices such as what they wanted to wear and what they wanted to eat. Staff respected the choices that people made and accommodated these wherever possible. However, staff were not always able to accommodate people's wishes because they told us they did not always have the time to do so. For example, people did not always receive a bath or shower as often as they would like. One person told us that their hair wasn't always washed when they requested it to be. Another person wanted to go for a walk outside and their care plan directed staff to do so each day, if possible. However, staff were busy on the day of our visit and were not able to take the person for a walk. People's relatives told us that staff kept them updated with regards any changes to their loved one's care and told us they were sometimes consulted about individual decisions. We also saw that staff explained what they were going to do prior to delivering any care and support to people.

People were provided with equipment, such as walking aids, to enable them to retain independence. The staff we spoke with described how they supported people to remain independent and we observed this happen. People were not provided with information about how they could access advocacy services, should they wish to speak to an independent person about their care. This meant people may not be able to speak about any concerns with an independent person should they wish to. An advocate is an independent person who can support people to speak up about the care service they receive.

The people we spoke told us they had positive relationships with staff and felt staff were caring. One person described staff as, "Very pleasant." They went on to say, "I find the care here to be very good. It's comfortable, staff are very pleasant." Another person commented, "They look after me very well." The relatives we spoke with told us that their loved ones were well cared for and that staff and people had positive relationships. One relative said, "They have different personalities (the staff). They come in all cheery. There are people who are quieter but the patience, I don't know where they get it from, absolutely fantastic."

We observed that staff treated people kindly and had individual relationships with each person. For example, one person became upset during the morning and the deputy manager spent time sitting and talking with the person to reassure them. Staff also spent time dancing with one person and told us they knew that the person had always been a keen dancer. Staff took the opportunity to share a joke with people but also knew when that would not be appropriate. The healthcare professionals we spoke with also confirmed that staff knew people well and were caring.

Staff spoke with and about people in a kind and considerate manner and appeared to enjoy spending time with people. The care plans we looked at contained a limited amount of information about the way in which people preferred to be supported. Staff had a more detailed understanding of people's preferences, likes and dislikes than was recorded. Care plans also contained some information about how people's religious and cultural backgrounds could influence the provision of care and support. A religious service was due to be held on the day of our inspection, however this did not go ahead as planned. Staff were unsure as to why it had not taken place and told us they would follow this up.

The people and relatives we spoke with told us they were treated with dignity and respect by staff. During our visit we observed that staff took steps to preserve people's dignity, such as asking if they wanted a protective cover to wear over their clothes at lunchtime. Staff spoke with people discreetly about any personal matters and ensured that any confidential discussions were not held in communal areas.

People were supported by staff who were aware of the importance of providing dignified care and respecting people's right to privacy. Staff were aware of the appropriate values with regards privacy and dignity and could describe the steps they would take to ensure personal care was given in a dignified manner. We observed staff asking for permission before entering people's bedrooms. People had access to a smaller, quiet lounge or their own bedroom should they require some private time. People were able to receive visitors at any time and there were no restrictions on visits.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with told us they did not always receive person-centred care and felt this was because staff were often too busy. One person told us that staff did not always respond as quickly as they would like when they called for help. Another person commented that they would like staff to sit and talk with them but added that they couldn't do so because they were too busy elsewhere. The relatives we spoke with provided mixed feedback with one relative telling us that their loved one did not always receive person-centred care. Another relative was very positive about the care and support that staff provided.

During our visit we saw that people did not always receive responsive care and there were delays in care and support being provided. Upon arrival at the home we noted that one person's arm was bleeding and notified staff. About an hour later staff had not been able to attend to the person and the blood had dried, we notified staff again. It was a total of two hours before staff were able to attend to the person. People were not always supported to change their position at the required frequency which left them at risk of developing a pressure ulcer. Staff had noted that one person's skin had broken on the night before our inspection. Another person was noted as being able to use the toilet but we saw they required staff to assist them to get to the bathroom. During our inspection staff did not support the person to access the toilet which meant their needs were not anticipated or responded to. The staff we spoke with confirmed they were not always able to meet people's needs in a timely manner. One staff member commented, "Sometimes we bring people down in their dressing gowns and shower them afterwards."

Staff told us they did not always have access to information about people's care needs. This is because they didn't have the time to read people's care plans. The majority of the care plans we looked at contained out of date or incorrect information about people's care needs. The administrator told us that they were in the process of being updated. However, it was noted on our previous inspection that care plans were often out of date or contained incorrect information. Whilst there were monthly care plan review documents in each care plan, they did not contain any information to suggest that people's care had been adapted in response to a change in their needs.

People did not receive person-centred care and their care plans did not accurately reflect their needs which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In spite of this, the staff we spoke with had a good understanding of people's needs and how they had changed over time. Staff told us that they did receive updates about each person during the shift handover and also if they had been away from work. Staff told us that they enjoyed working at the home and endeavoured to provide the best care they could for people, sometimes staying past the end of their shift. On the day of our inspection some staff stayed beyond the end of their shift in order to support the afternoon staff.

The people we spoke with provided mixed feedback about the provision of activities in the home, although noted that staff generally didn't have the time to do activities with them. The relatives we spoke with also provided mixed feedback about activities. One relative said, "They don't have an activities person. If they just

had music, [my relative] would like to listen to music." Another relative told us, "They take them (people living at the home) up to the café at the garden centre or on a boat ride."

During our visit no activities were provided because staff were busy trying to provide personal care and support to people. There was no activities co-ordinator employed and staff told us it was down to them to provide activities when they could. Staff commented that they often struggled to find the time to spend with people carrying out any meaningful activity. Many people spent long periods of time sleeping or not engaged in any activity. During the afternoon period several people became restless and agitated. The deputy manager told us they were aware of people's hobbies and interests and had some ideas about activities that could be provided to occupy people.

The people we spoke with were not always aware of a complaints procedure being in place but felt they could raise concerns or make a complaint. One person said, "I don't know anything about the complaints procedure." Another person told us, "I'd tell a member of staff I suppose (about a complaint), or my family." The relatives we spoke with told us they felt able to make a complaint to the manager. One relative commented, "I've never used it but I've been told."

The provider's complaints procedure was available to people and relatives and a copy was provided upon admission to the home. No complaints had been received since our previous inspection so we could not assess how they had been responded to. The deputy manager and other staff told us that they felt any complaints would be taken seriously and investigated.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in January 2016 we found that systems in place to assess and monitor the quality of the service were not effective in identifying issues or bringing about improvements to the quality of the service. In addition, there were limited opportunities for people to provide their feedback about the service they received. The provider submitted an action plan detailing the improvements they planned to make. During this inspection we found that improvements had not been made.

People were not always aware of ways in which they could give their opinion about the quality of the service. One person said, "I haven't had such an opportunity (to provide feedback)." Another person, when asked if they had been asked to provide their feedback about the service, said, "No, They'd rely on me to tell them." One of the relatives we spoke with confirmed that they had completed a satisfaction survey with their loved one.

People were not routinely asked for their opinion about the quality of the service they received. There had been no meetings for people or their relatives to attend since our previous inspection. This meant that there was a missed opportunity to obtain feedback about any improvements that could be made. A satisfaction survey had been distributed shortly after our previous inspection, however we were not able to view the responses as they were in a cupboard which could not be opened. The deputy manager was not sure if any work had been done to analyse the survey responses or identify if any improvements had been identified and acted upon. There were limited opportunities for staff to get together to discuss the service and raise any concerns or suggestions. There had only been one staff meeting since our previous inspection and none for a period of about eight months. This meant that staff were not always able to be involved in the running of the service and any ideas they may have about improvements may not be heard.

There weren't robust systems in place to assess the quality of the service provided or to monitor and mitigate risks to people. Some audits were carried out, however these were not effective in bringing about improvements. For example, a monthly infection control audit had been carried out but this had not identified the issues raised by an external infection control visit. On the day of our inspection the deputy manager identified several mattresses as requiring replacement. A recent infection control audit had identified that the mattresses were in satisfactory condition.

Other audits which would prove beneficial had not been carried out. For example, a medication audit tool was available but this had not been used. This meant that, should any issues arise with medication administration, these may not be acted upon in a timely manner. There had been no analysis of the falls that had occurred to try and detect any patterns. There had been a number of falls since our previous inspection, whilst staff had taken action in the immediate aftermath of each fall, there had been no attempt to understand why the falls had happened and if anything could be done to reduce the risk of similar incidents happening again.

Confidential records relating to people's care were not always securely stored. Staff maintained daily records about the care provided to each person, these were kept in an open trolley inside a staff office. We

saw that this office was routinely left unlocked and unattended throughout the day. In addition, other records that we requested could not be accessed because they were in a locked cupboard. We were told that only the registered manager had the key for the cupboard and they weren't present during our inspection.

The lack of robust quality assurance processes and risk management measures meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the lack of formal opportunities to provide feedback, the majority of the people and relatives we spoke with felt that the culture of the home was open and that they could speak up if they wished to. During our visit we observed that people and visitors to the home felt comfortable speaking with the staff, deputy manager and administrator. Staff also worked well as a team and maintained communication with each other, despite the pressures on their time.

The staff we spoke with felt there was an open culture in the home and they felt comfortable raising concerns or saying if they had made a mistake. One staff member said, "I would tell someone straight away if I made a mistake. I think it would be dealt with fairly." Records we looked at showed that CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

There was a registered manager in post but they were not present during our inspection. The people we spoke with were not always aware of who the registered manager was and provided mixed feedback about their leadership and visibility. One person said, "Oh yes, I don't see [the registered manager] very often. I don't know if [the registered manager] is on holiday or where they are." The relatives we spoke with knew who the registered manager was and told us that they found them to be approachable.

The staff we spoke with felt that the registered manager provided good leadership and helped out 'on the floor'. However, the registered manager was not always able to provide consistent leadership because they also managed another service operated by the provider. This meant that their time at South Collingham Hall was limited. Whilst the deputy manager and senior care staff endeavoured to provide management cover, they did not always have the time to do so as they were busy providing care. This had an impact on the overall governance of the home. For example, there had not always been a positive response to visits carried out by other agencies. For example, the fire service had carried out a visit which identified remedial works as being required and an infection control visit had also identified numerous areas for improvement. During our visit we saw that the provider and registered manager had failed to respond appropriately to the recommendations made and that the required improvements had not all been made.
Resources were not always made available to support staff to provide good care and to enhance people's quality of life. For example, we were told that limited resources were provided to fund activities. This had meant that the home had recently relied upon fund raising drives to pay for an entertainer to visit the home. Many areas of the building were neglected and required extensive repair and refurbishment work. The provider did not routinely visit the home to assess the quality of the service or identify what improvements were needed. The people and staff we spoke with confirmed that they very rarely saw a representative of the provider and did not always know who they were.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care provided to people was not appropriate, did not meet their needs or reflect their preferences, Regulation 9 (1) (a), (b) and (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not always acted in accordance with the Mental Capacity Act (2005). Regulation 11 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety were not appropriately assessed and steps to mitigate any such risks had not always been taken. Regulation 12 (1) & (2) (a) and (b). The premises and equipment used by the service provider were not always safe to use for their intended purpose. Regulation 12 (2) (d) and (e). Steps had not been taken to prevent, detect and control the spread of infections. Regulation 12 (2) (h).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet people's needs. Regulation 18 (1).

Person's employed had not received appropriate training to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a).

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	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) & (2) (a). Systems were not operated to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) & (2) (b). Records were not always kept contemporaneously or securely. Regulation 17 (1) & (2) (c). People's feedback was not always sought or acted upon. Regulation 17 (1) & (2) (e).

The enforcement action we took:

We issued a warning notice.