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Meadowview Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 7 and 11 August 2017. At our inspections in March 2015, January 2016 and December 2016 we found the service was not always well led. Systems to monitor and improve the quality of the service were not effective. The consistency of the quality of the governance systems operated by this provider has been a concern since 2015. Improvements have not been made to ensure the provider is consistently able to meet the requirements of the regulations. As a result people have not received care that is safe, effective, caring and responsive to their needs.

Meadowview Nursing Home provides accommodation and nursing care for up to 42 people. At the time of the inspection there were 28 people using the service.

There was no 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 three different managers since January 2017. The provider had recruited a new manager who was planning to make application to CQC to become the registered manager.

Medicines were not managed safely and risks associated with people's health needs were not managed effectively. Systems to reduce the risk of infection were not maintained. The environment and equipment were not always clean. Systems to reduce the risk of fire were not monitored.

People's needs were not met in a timely manner and staff were not deployed in a way that ensured people's needs were met. Staff did not have the skills to communicate in a meaningful way with people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

The quality of the food was not always good and people did not always receive food and drink to meet their needs.

Staff did not always treat people with dignity and respect. People told us staff were not always caring and people spent long periods without any interaction.

Care was not provided in a person-centred way. Staff did not always respond to people's requests for support in a timely manner.

People and their relatives were not confident to raise concerns. They felt that no action would be taken to resolve issues and were fearful of retribution if they complained.

Systems in place to monitor and improve the quality of the service were not effective. Where steps had been taken to gather feedback about the service no action had been taken to resolve the issues identified.

Staff felt supported through regular supervision and were positive about the training they received.

We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People were not supported in a safe way.

Medicines were not managed safely.

Where risks were identified steps were not taken to mitigate the risk of harm to people.

Sufficient staff were not deployed in a way that ensured people's needs were met.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have the skills to communicate effectively with people.

Staff did not have an understanding of how to support people in line with the principles of the Mental Capacity Act 2005.

People did not receive food and drink to meet their individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by staff who were kind and caring.

People were not supported in a way that promoted their independence.

People were not always treated with dignity and their privacy was not protected.

Is the service responsive?

Inadequate

The service was not responsive.

People were not supported in a way that met their individual

needs.

People spent long periods with no interaction from staff and did not have access to meaningful activities.

The system to enable people to raise complaints was not effective. People were not confident in the response of the provider and were reluctant to raise concerns.

Is the service well-led?

Inadequate

The service was not well led.

The service had a history of ineffective quality improvement systems. Improvements had not been sustained.

The provider did not have an effective system to enable them to have an overview of the service.

There was a poor culture that did not put people at the centre of the service.

Meadowview 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 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 7 and 11 August 2017 and was unannounced.

The inspection was carried out by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.'

Prior to the inspection we looked at information we held about the service. This included previous inspection reports and notification received from the service. Providers are required under the law to send notifications to CQC relating to specific events. We also spoke with the commissioners of the service.

During the inspection we spoke with 15 people and 18 relatives and visitors. We spoke with the provider, the home manager, the deputy manager, the clinical lead, two nurses, two senior care workers, four care workers, two activity coordinators, the chef and the maintenance person.

We observed practice throughout the inspection and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at 13 people's care records, including medicine administration records (MAR), six staff files and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our inspections in March 2015, July 2015, January 2016, June 2016 and December 2016 we found that the service was not always supporting people in a safe way. The issues identified at these inspections included the management of medicines and the assessment and management of risk associated with people's care. In January 2016 we issued a warning notice advising the provider that the regulations must be met by 29 March 2016. At the focused inspection in May 2016 we found the regulations had been met. However, improvements were not sustained and at our inspection in December 2016 we found further concerns relating to the assessment and management of risks. Following the inspection in December 2016 we imposed conditions on the provider's registration requiring them to send monthly reports to the commission about the improvements they were making. At this inspection on 7 and 11 August 2017 we found improvements had not been made.

Some relatives told us they felt people were safe. Comments included; "[Person] is safe there, we can go away knowing there are no problems" and "[Person] is alright here and safe". However, comments from other relatives and the records we looked at did not corroborate this opinion.

Medicines were not always managed safely. Action was not always taken to ensure people received their medicines as prescribed. For example, one person was prescribed pain relief three times per day. The person's medicine administration record (MAR) showed they had not received their pain relief medicine for six days. The nurse administering the medicines told us the person had declined their medicine. However, the person was assessed as lacking capacity to make decisions in relation to their care and treatment. There was no guidance in place to support staff with knowing when the person was in pain and would require their medicine. No action had been taken in response to the person declining their medicine. This demonstrated that the system for proper and safe management of medicines was not effective.

People did not always receive their medicines as prescribed. For example, one person was prescribed a topical medicine to be applied three times a day. The person's MAR showed the topical medicine had only been administered twice a day. We asked the clinical lead why records showed the person was only receiving their prescribed medicine twice a day the clinical lead was not able to give an explanation. This meant people did not receive their medicines to ensure their health and well-being was maintained and improved.

Staff did not always administer medicines in a way that ensured they were effective. For example, we saw one person was supported with an inhaler. The nurse stated, "You need two puffs". When the nurse was administering the medicine the person moved their face away from the equipment. The nurse administered another dose of the medicine. However, the equipment was not placed in the correct way and the person did not receive the medicine. The nurse took no further action to ensure the person had their medicine as prescribed.

Staff had completed medicines training. Staff records contained no competency assessments to ensure they had the skills to administer medicines safely. The provider's medicines policy stated "Ensure that staff

handling medicines have the competency and skills needed". We spoke to the manager who was not able to tell us about the system for monitoring staff competencies in relation to medicines administration. The manager contacted the clinical lead who advised the manager that they carried out competency assessments as part of supervision. However, there was no record of competency assessments on the supervision records we saw for staff responsible for administering medicines. One member of staff who was responsible for the administration of medicines told us, "I'm checked for administering medicines competency observation". However, there was no record of the medicines competency assessment for this member of staff.

Where people were receiving their medicines covertly the provider had not consulted with the dispensing pharmacist to ensure that it was safe to administer the medicines in a covert manner. Covert administration of medicines means when medicines are administered in a disguised format without the knowledge or consent of the person receiving them. There was no information to guide staff in how the medicine should be administered covertly. This was not in line with national guidance for administering covert medicines in care homes.

People's care plans contained risk assessments relating to: falls; nutrition; medicines and skin damage. However, risk assessments were not always accurate and there were not always plans in place to identify how risks would be managed. For example, one person had a risk assessment identifying they were at high risk of falls. The risk assessment identified that this level of risk required consideration of placing a mattress on the floor when the person was in bed; referring the person to the falls prevention service and having their medicines reviewed by the person's G.P. However, there was no evidence that any action had been taken to mitigate the risk of falls for this person.

Some relatives were concerned about the cleanliness of the service. Comments included: "Just about clean enough but you wouldn't want it to be any worse"; "Cleanliness is a big issue"; "I would not know when [person's] basin was last cleaned" and "When I pick things up in [person's] room they are always sticky and I end up cleaning them".

There was a strong unpleasant odour on entering the service for the inspection. There were areas of the service that were not clean and presented a risk in relation to infection control. For example, one person had stained and damaged protective bumpers on their bed rails. Cleaning records for people's rooms indicated rooms were cleaned daily but did not detail what cleaning had been completed. There had been no infection control audit since January 2017.

Systems to manage the risks associated with fire were not effective. During the inspection the fire alarms were tested. We saw seven fire doors did not close in line with fire legislation when the alarm sounded. One fire door did not have an automatic closer fitted and did not close when the fire alarms sounded. We spoke to the provider who told us the door was not a fire door and removed the fire door sign. On the second day of the inspection a door closer had been fitted. Fire records showed that the fire doors were not being checked regularly and had not been checked since June 2016.

There was a 'grab box' that contained easily accessible information required in an emergency. However, information in the grab box was not up to date. For example, there was information relating to people's contact details. There was information for seven people who were no longer living in the service. Medicine administration records stored in the grab box were not up to date.

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

Some people and relatives told us there were not always enough staff. Comments included: ""They're a bit short staffed"; "They're clearly a bit short staffed" and "I find they are short of staff". People told us that responses to call bells were not always prompt. One person told us they used their call bell and added, "Yes, but response time is variable". Another person said, "If you're lucky they come" and "It's half and half whether they help you".

Staff we spoke with told us, "I would like more one to one time with people" and "We are quite short staff. A lot of people need assistance with eating or two staff. It can be difficult".

During the inspection staff were busy and people's needs were not always responded to in a prompt manner. For example, one person asked for a glass of water. The member of staff did not return with the drink for 55 minutes.

People's care plans contained a dependency assessment tool identifying people's level of dependency. However, there was no record of how these assessments were used to determine required staffing levels.

The manager told us what they considered were the required staffing levels in the service and rotas showed that these staffing levels were met. However, we could not be sure that there were sufficient staff deployed to meet people's needs as throughout the inspection people's needs were not met in a prompt manner.

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

Staff told us they had completed safeguarding training and knew how to raise their concerns in relation to the abuse of people. Staff comments included: "I understand about safeguarding. If I saw a bruise I would report it to a nurse or management who report to social services", "I would report to the manager straight away" and "I would report to the nurse or if need the manager". However, not all staff were aware of where to report their concerns outside of the organisation.

The provider had safeguarding policies and procedures in place. Records showed that appropriate action had been taken when safeguarding concerns had been raised.

We looked at records relating to staff recruitment. Recruitment records showed relevant checks had been carried before staff worked in the home. Checks included employment and character references and Disclosure and Barring Service (DBS) checks. This enabled the provider to make safer recruitment decisions and ensure staff employed were suitable to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

People told us staff did not always have the skills and knowledge to meet their needs, particularly in relation to staff's ability to communicate with people. Comments included: "Language is difficult"; "I wish they could speak better. They're mostly foreign, it doesn't help"; "I can hardly understand them" and "Some of them are very hard to understand. You just have to put up with it". Relatives were also concerned about the ability of staff to communicate with people. One relative told us, "A concern of mine is that all of the staff I see are foreign. Although they are caring I do not think most of the residents can understand them".

A member of the management team told us, "It (the job) is impossible to do properly because of the poor language skills of some staff". They told us staff struggled to understand basic requests and misinterpreted questions. They said, "They [care staff] are very caring people but their skills in communicating effectively have an impact upon the people in the service".

During the inspection we saw people having difficulty understanding what staff were saying to them. For example, a member of staff who did not have English as their first language was speaking with people about the choices available for lunch. The member of staff told one person what was for lunch. It was clear from the person's response that they had not understood what had been said. The member of staff made a decision for the person and told them what they would give them for lunch.

We spoke with staff. It was clear from some staff's response to questions asked by inspectors that they did not have a clear understanding of what was being said. For example, we asked a member of staff about the odour in the home. The member of staff responded in relation to the temperature of the home at night. We could not be sure staff were able to communicate with people in an effective manner.

The manager told us the provider used an agency to recruit staff from abroad. However, there was no system in place to enable the provider to assess staff communication skills when they commenced working in the service.

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

People were not supported in line with the principles of the Mental Capacity Act 2005 (MCA). 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.

Care plans did not always contain capacity assessments where there were indicators that a person may lack capacity to make decisions in relation to their care and treatment. For example, one person had a diagnosis of dementia. The care plan stated the person required bed rails and a bed rail consent form had been signed by a relative. There was no capacity assessment determining whether the person had capacity to consent to

the bed rails.

Where people had been assessed as lacking capacity to make a decision relating to their care and treatment there was not always evidence that a best interest process had been followed. For example, one person lacked capacity to consent to sharing a room. There was no record of anyone being consulted to ensure the decision to share a bedroom was in the person's best interest.

People's care plans contained consent forms that had been signed by relatives. There was not always evidence that the relative signing the consent form had legal authority to do so. For example, one person's relative had signed a consent to photograph form and a consent to bed rails form. The care plan contained no evidence that the relative had authorisation to sign the forms on the person's behalf.

Where people had designated a representative to have legal authority to act in relation to aspects of their lives, care plans did not always contain details of the legal authority the representative had been awarded. For example on person's care plan stated, "Son has lasting power of attorney (LPA)". The care plan did not state whether the relative had authority to make decisions in relation to property and affairs or health and welfare. There was no copy of the LPA held by the service to identify what authority the representative held.

Staff had completed training in MCA. However, staff were not always clear about how they should support people in line with the principles of the act. For example, when speaking with staff about their responsibilities to support people who may lack capacity to consent to care one member of staff told us, "I would go for help". The member of staff was not aware of best interest decisions or least restrictive practice. A nurse was not aware of their responsibilities to support people in line with the principles of the act and told us, "I don't know. Fill in special forms"?

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

Some people were positive about the food they received. For example, one person said, "I enjoy the food". Other people were not positive about the quality of the food they received. People's comments included: "Some of the food is tasteless"; "Honest food but sometimes it's a bit poor"; "They go over the top with ice cream" and "Quality of food could be improved".

Some relatives also shared concerns about the quality of the food. One relative told us, "[Person] has lost weight. Food and drink; they certainly get some weird choices".

The menu choice on the first day of the inspection was 'sausages with onion gravy' or fish fingers. At lunchtime we saw that people were served fish fingers with onion gravy. One person said, "Who has fish fingers with gravy on"? The person was not offered fish fingers without gravy. Another person was given fish fingers with onion gravy. The person did not eat the meal and was not offered any alternative.

People did not always receive food and drink to meet their nutritional needs. For example, one person's care plan stated "Must have sugar free and low carb diet". We saw the person was eating ice cream for their dessert. We were advised by the chef that the ice cream was not sugar free. The information on display in the kitchen stated the person was on a normal diet. There was no information relating to the person's dietary needs or that they were diagnosed with diabetes.

People's nutritional intake was not always monitored in line with the guidance in their care plans. For

example, one person's care plan identified the person's food intake should be recorded to monitor the intake of carbohydrates in order to manage their health condition. There was no food intake chart for the person. A member of staff told us the person no longer required their intake monitored as they had gained weight. However, monitoring the person's carbohydrate intake had not been due to the risk of weight loss. This demonstrates that staff did not understand people's needs or deliver care to meet those needs.

People's care plans identified people's dietary needs. However, people did not always receive food and drink in line with the guidance in their care plans. For example, one person's care plan identified they required fortified food and drink. The care plan stated "Give fortified milk drinks. Offer at least 200mls four times a day". The fluid record for this person did not contain any record of fortified drinks.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were supported through regular supervision and appraisals. Records showed that most staff had received supervision and that development opportunities were discussed.

Nurses were supported to maintain their professional registration and had opportunities to update their clinical skills. For example, the training record for one nurse showed they had completed training in catheterisation.

Staff were positive about the training they received. One member of staff told us they had completed training to understand how to support people with learning disabilities, and how this had helped them to understand what some behaviour may indicate.

People were supported to access a range of health professionals. This included regular G.P visits, referrals to Care Home Support Service (CHSS) and Speech and Language therapy (SALT). We saw that where people's needs identified additional support this was accessed appropriately. For example, one person was calling out from their room. We saw the person had been referred to the community mental health team who had visited and carried out an assessment. They were working with the service to develop strategies to support the person.

Requires Improvement

Is the service caring?

Our findings

People did not always feel staff were kind and caring. Comments included: "Some of the time the care is good, some of the time it could be better"; "Some people who shout and struggle are not helped"; "They (staff) can be a bit rough" and "If you are all waving and upset it is not right what they do, that only makes you more angry that you're treated that way". One person told us staff did not respond in a positive way when they used their call bell. The person said he was asked, "Why did you ring it and why do you keep ringing it".

Some relatives told us they felt staff were caring. One relative told us, "Staff are very friendly and caring". However, other relatives had some concerns about the care people received and did not feel people were treated with dignity and respect. Relatives comments included, "I don't see any interaction (from staff) with residents or relatives"; "All [person's] clothes have gone missing. [Person] always wears someone else's clothes" and "[Person] has never smelt in their whole life but when I went in (date) [person] did smell. When I came back the next week [person] was wearing the same dirty clothes".

During the inspection we saw some staff did not interact with people when supporting them. For example, one member of staff was serving people with their lunch. Trays with meals were placed in front of people with no explanation and without speaking to people. Staff placed protective clothing around people before meals were served. Staff did not seek people's permission or explain what they were doing.

On several occasions we saw staff walk through communal areas without acknowledging people or responding to indicators that people required support. On other occasions staff responded by saying, "I'm busy" when people asked for assistance. This meant people's wellbeing was not supported through interaction with staff.

People were not always supported to maintain their independence. For example, we saw one person eating their breakfast independently. At lunchtime we saw the person was being fully supported to eat their meal. The person's care plan stated, "[Person] is able to eat and drink independently. Needs encouragement to eat".

People's information was not always protected. For example, one relative told us how a member of the management team had spoken with them about a private matter in a communal area of the home in front of staff and other people. The relative told us, "I didn't like that being said in public".

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with had not been involved in the development of their care plans. Relatives were not always involved in the development of people's care plans where it would have been appropriate to consult with them. One relative told us, "I never receive a copy of [person's] care plan. I used to badger [manager] for a copy but they always ignored my emails. I get one now but only via social services". Another relative said, "I

don't know if [person] has a care plan".

We observed some kind and caring interactions. For example, a nurse approached a person, who smiled readily at the nurse. The nurse held the person's hand and encouraged her to drink, smiling and making eye contact. The person drank well and the nurse commented, "Amazing, [person] hasn't done that before". The nurse was clearly pleased the person had managed to drink.

The service supported people with end of life care. However, at the time of the inspection there was no one receiving end of life care.

Inadequate

Is the service responsive?

Our findings

People did not always receive care and support to meet their needs. For example, one person was admitted to the service with a catheter. The person's care plan showed the person's catheter required replacing every 12 weeks. There was no record to show the catheter had been changed at the appropriate intervals. We spoke to a member of staff who told us the person had declined to have the catheter changed. There was no record of the person declining until four weeks after the date the catheter was due to be changed. No action had been taken following the person declining the support.

People did not always receive support to meet their individual requests. For example, one person was asked if they would like a drink. The person asked for a cup of tea. The member of staff responded by advising the person they only had orange squash. The person responded, "That will do". There was no willingness by the member of staff to provide the person with the drink of their choice.

Staff were not always responsive to people's requests for support. One relative told us, "Residents are often left unsupervised. Residents are often calling for the toilet and are often not reacted to. The response is often slow and I have seen some wet (incontinent of urine), especially those that can't shout".

During the inspection we saw people spent long periods of time without interaction with staff. For example, on one occasion people sat for 30 minutes with no member for staff entering the communal area to ensure people's needs were being met. One person told us people referred to this lounge area as "The sad room".

People did not have access to activities that interested them. One person told us, "There's not much to do here". Relatives told us people spent significant amounts of time with no interaction. Relative comments included: "There is little stimulation for [person]"; "Sometimes [person] feels he's forgotten in his room" and "I have to say the stimulation of the residents is not always obvious".

There were two activity coordinators employed in the service. However, we observed that people were not always engaging in the activities that were taking place. For example, one activity coordinator was trying to engage a person completing a puzzle. It was clear the person was not able to participate in the activity and fell asleep. One relative told us, "(Activity staff) just seems to do puzzles with the same residents".

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records were not always an accurate reflection of people's likes and preferences. For example, one person's care plan stated the person should be encouraged to join in activities and leave their room. However, the person's relative told us, "[Person] always likes being on her own. Always has, she was often alone, nearly always alone".

Care records contained conflicting information and were not always accurate. For example, one person's care plan identified the person needed fluids to be thickened. The thickening agent was prescribed by the

person's G.P and was recorded on the person's medicine administration record (MAR). The MAR indicated the person received the thickener four times daily. A fluid chart was completed to record the person's fluid intake. The fluid chart did not contain entries that correlated with the times the thickening agent was signed for on the MAR. There was no record to confirm the person received fluids at the times indicated on the MAR and there was no record on the fluid chart to confirm that fluids that had been given were thickened in line with the guidance in the person's care plan.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy and procedure in place. However, people were not always confident to raise concerns. One person said, "I don't ask. It's a waste of time". Some relatives were not confident to raise concerns and felt issues were not always responded to in a positive manner. Comments included: "I regret to say I now turn a blind eye to some of the goings on there (Meadowview Nursing Home). I've utterly and completely given up"; "If I complain too much I think they might take it out on [person]"; "Everything was swept under the carpet"; "I've voiced my concerns in the past but it falls on deaf ears, so I gave up" and "If I speak with [member of management team] I know it falls on deaf ears. I only want the best care though". One relative who spoke at length about their concerns told us, "It is difficult for me to tell you all these things but it all builds up".

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records relating to complaints and there was one complaint recorded since our inspection in December 2016. We saw that the manager had investigated and responded to the complaint in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

At our inspections in March 2015, January 2016 and December 2016 we found the service was not always well led. Systems to monitor and improve the quality of the service were not effective. The consistency of the quality of the governance systems operated by this provider has been a concern since 2015. Improvements have not been made to ensure the provider is consistently able to meet the requirements of the regulations.

Following the December 2016 inspection we imposed conditions on the provider's registration requiring them to send monthly reports to the commission about the improvements they were making. The information supplied within the reports indicated the service should have been meeting the requirements of the regulations. However, at this inspection on 7 and 11 August 2017 we found improvements had not been made and there were multiple breaches of the regulations. During feedback to the provider and manager at the end of the inspection the provider indicated that they were under the impression that they were meeting the requirements of the regulations.

The lack of effective systems to enable the provider to have an oversight of the quality of the service meant the issues found during the inspection had not been identified.

Some relatives told us they felt the service was good. However, comments from people, other relatives and our observations did not corroborate this. The service was not well-managed. Relatives told us there was little direction from the management team to ensure staff knew their roles and responsibilities. One relative told us, "I don't see that the carers are getting much direction". Another relative said, "I don't see a level of seniority in the staff".

Systems to obtain feedback about the service were not effective. A quality assurance questionnaire had been sent out prior to the inspection. Some responses had been received and the manager told us they would analyse the responses and complete an action plan when all of the responses had been received. However, one response raised concerns about a person not wearing their hearing aids. There was no evidence that any action had been taken to address the issue.

Methods of communicating with and seeking feedback from relatives were not always effective. Relatives told us, "I wouldn't ever know if they were holding a fete, an 11/11 commemoration or anything"; "No one phones from the home to update me" and "They don't tell me about anything; about fetes, open days".

The staff told us there were daily handovers at the beginning of each shift to ensure staff had up to date information about people and how their needs should be met. However, information was not always shared. For example, one person's care plan stated they required fortified drinks. The fluid intake records showed the person was not receiving fortified drinks. We spoke with the clinical lead who told us the person did have fortified drinks. The clinical lead spoke with staff who said the person did not like the fortified drinks and was therefore not receiving them. This meant communication systems were not always effective which put people at risk of their care needs not being met.

Systems to monitor and improve the quality of the service had not identified the issues found during the inspection. There was a range of audits completed which included, care plans, weight loss and observations of staff practice. However, the audits were not effective. For example, the audit of people's weight loss identified who had lost weight each month but actions had not been taken in line with the guidance in people's care plans. The overview of people's weight loss had not been updated since May 2017 and had resulted in some people's food and fluid intake not being monitored as required.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no 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 three different managers since January 2017. The provider had recruited a new manager who was planning to make application to CQC to become the registered manager.

People and their relatives were not always kept informed of changes in the service. For example, there had been several changes to the home manager in the last 12 months. Relatives comments included; "Three different managers recently. Why no notification. Any changes in management are a bit of a concern" and "I've not been made aware of any changes in management".

The management team did not promote a positive culture in the service. We observed the provider and home manager walking around the service. They regularly walked past people in communal areas without any interaction. Where people were calling out in their rooms we observed members of the management team passing the rooms without checking on people's well-being.

The provider had a whistleblowing policy in place. One member of staff told us, "I know about the whistleblowing policy and procedures. If nothing was done, then I would contact social services or CQC".

The provider sent in appropriate notifications to CQC.

There were systems in place to monitor accidents and incidents to look for trends and patterns. Accident and incident records identified what action and been taken to minimise the risk of a reoccurrence.