HC-One Limited

Overdene House

Inspection report

John Street
Winsford
Cheshire
CW7 1HJ

Tel: 01606861666
Website: www.hc-one.co.uk/homes/overdene-house/

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Overdene House is registered to provide support for up to 70 older people, or people living with a physical disability who require nursing and personal care. At the time of the inspection there were 50 people living within the service.

We previously carried out an unannounced comprehensive inspection of this service on 15 February 2017. Breaches of legal requirements were found. After the comprehensive inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified that the required improvements had not been made and there were continuing breaches of Regulations 12 and 17.

This inspection was unannounced and took place on the 21 April 2017 and the 9 June 2017. The inspection initially started as a focussed inspection to look at concerns that had been raised in relation to the 'safe' and 'well led' domains. However, following the first day of the inspection we received concerns that were being investigated by the police and the local authority safeguarding team. This resulted in us revisiting the service on the 9 June 2017 to carry out a full comprehensive inspection. The report cannot comment on the concerns being investigated by the police, as the investigation is still underway.

The service did not have a registered manager in post. The previous registered manager had left shortly before the inspection in April 2017. At the time of the inspection visit the deputy manager was running the service with support from the area director. 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.

At the last inspection we identified a breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems were not effective at ensuring the safety and quality of the service being provided, the premises were not always safe and secure, the call bell system was not functioning and people were not always being protected from the risk of malnutrition. At this inspection we found that not all the required improvements had been made. This has resulted in a repeated breach of Regulations 12 and 17. In addition to this we have also identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to issues around staff training and supervision.

People were not always protected from the risk of harm. For example, during the inspection we identified that one person had managed to abscond from the service on two separate occasions over a period of four days without the required level of support. In another example staff did not have a good knowledge around people's dietary needs which had resulted in two people being given an inappropriate diet, and one person choking. In both examples effective measures had not been put in place following initial incidents which had

enabled the incidents to reoccur. This showed poor risk management and placed people at ongoing risk of harm.

Parts of the environment were not always safe. The lift motor room door was left unlocked, and a cupboard containing electricals which displayed hazards signs was also left open. This placed people at risk of injury should they access these. On the second day of the inspection we found these to be secure.

Audit systems were not always robust. For example, medicines audits showed that an analysis of information relating to variances in stock levels had not been carried out, which meant that the registered provider could not be sure that people had received their medication as prescribed. In three instances we identified that people's prescription items had not been reordered as required which placed them at risk of discomfort and harm.

Staff had not always received the training they needed to carry out their role effectively, and staff had not received supervision and appraisals. This had been identified during our previous inspection in November 2016, and during an internal audit carried out by the registered provider in February 2017. Despite this, appropriate action had not been taken to address this.

The registered provider had not notified the CQC of two events that had occurred within the service as required by law. After this was raised with the manager these were submitted to the CQC.

Staff morale was low, and two members of staff told us that they did not feel able to openly raise concerns with external organisations for fear of reprisals. Following the inspection the registered provider informed us that they had an anonymous whistleblowing call line in place for staff to raise concerns.

The majority of staff were task oriented in their approach. We observed examples where staff were gathered talking amongst themselves in groups, rather than interacting with the people in their care. We also identified that staff did not interact with people outside of delivering care and support to people. Despite this, staff demonstrated a kind and caring approach whilst they were providing support to people.

At the last inspection in November 2016, we made a recommendation that the registered provider sought different ways of gaining feedback from people using the service, their family members, professionals and staff. During this inspection we identified that the registered provider had made improvements relating to this.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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

The service was not safe.

People were not always protected from the risk of harm, and there had been 'near miss' incidents which could have placed people at risk of serious injury.

Parts of the environment that were potentially hazardous to people had been left unlocked.

Where one person had managed to abscond from the premises, preventative action had not been taken in a timely manner to prevent this from occurring a second time, or prevent other people from doing the same.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received the training and supervision necessary for them to carry out their role effectively.

Kitchen records did not always accurately reflect people's dietary needs and staff did not have a good knowledge around this.

A majority of people had been supported to access support from health professionals where required.

Is the service caring?

Requires Improvement

The service was not always caring.

Steps had not been taken to ensure people were protected from the risk of pain and discomfort.

Staff were task focused in their approach and did not always engage with people outside of the delivery tasks relating to people's support needs.

People's relatives told us they were made to feel welcome within the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always contain accurate and up-to-date information, and review processes were not always effective.

There was a complaints process, however the policy around this had not been made accessible to people using the service.

Activities were available for people using the service.

Is the service well-led?

Inadequate

The service was not well-led.

There was not registered manager in post and there had been a high turn- over of management.

Audit and quality monitoring systems were not always effective.

The registered provider had failed to notify the CQC of two events that had occurred within the service.

Overdene House

Detailed findings

Background to this inspection

We undertook an unannounced inspection of Overdene House on the 21 April 2017 and the 9 June 2017. Initially we undertook the inspection to done to check that improvements to meet legal requirements planned by the provider after our inspection in November 2016 had been made, and in response to concerns we had received. Following the first day of the inspection we received further concerns which resulted in us carrying out a comprehensive inspection.

Prior to the inspection we spoke with the local authority's safeguarding and commissioning teams. They raised concerns around the safety of people using the service. We also reviewed information that we held on our system regarding the service, which we used to help plan the inspection.

During the inspection we 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.

The inspection was undertaken by two adult social care inspectors on the first day of the inspection, and three adult social care inspectors on the second day. During our inspection we spoke with 10 people using the service and three family members. We spoke with six members staff, the deputy manager, interim manager, turn around manager and another member of the registered provider's management team. We also spoke with a visiting health professional. We looked at the care records for 11 people using the service. We looked at the recruitment records for two new members of staff who had started the service since the last inspection. We made observations on the interior and exterior of the premises, and looked at records pertaining to the day to day management of the service, such as audits and maintenance records.

Inadequate

Is the service safe?

Our findings

People commented that they felt safe using the service. One person confirmed that staff monitored their skin to ensure it was in good health and told us that staff took appropriate action to apply cream, or report to relevant health professionals if there was any deterioration. One person also commented, "The service is good. I feel safe". Another person who required specialist equipment in order to ensure care was provided appropriately commented, "They [staff] always use the appropriate equipment, but sometimes agency staff don't know what they're doing". A family member told us, "[My relative] is treated well. They're wonderful". We spoke with a visiting professional who did not raise any concerns regarding people's physical health.

At the last inspection in November 2017 we found that people were not always protected from the risk of harm. During this inspection we identified that whilst some action had been taken to make improvements, people remained at risk of harm.

At the time of the inspection a member of staff had raised safeguarding concerns in relation to people living at the service. These were in the process of being investigated by the police. Whilst we are unable to comment on the nature of the concerns raised, the registered provider had acted with full transparency and were co-operating with the investigation.

During the inspection visit on the 9 June 2017 the manager informed us that one person who required a soft food diet due to swallowing difficulties had been given a piece of toast. This had resulted in the person choking which had required staff to intervene by slapping them on the back to dislodge the obstruction. We spoke with staff that had observed the incident and were not aware that the person required a special diet. We looked at the information kept in the kitchen regarding people's dietary needs, and found that records did not include that this person required a soft food diet. This had placed this individual at risk of death. Following the incident this was reported to the local authority safeguarding team, and the manager started the process of reviewing all information kept around people's dietary needs to ensure it was correct. Following the inspection visit, incident records showed that a second incident had occurred where it was recorded that another person had been given biscuits when they required a pureed diet. This had placed this person at risk of choking, and demonstrated that staff knowledge had not improved around people's dietary requirements. The registered provider has been requested to do a thorough investigation of this incident.

One person with complex physical and mental health needs had managed to leave the premises without the required level of support on two occasions over a period of four days. An investigation had not been completed following the initial incident to determine how this had happened. This meant that adequate consideration had not been given to preventing this incident from reoccurring, which had led to the incident occurring a second time. This showed that the premises were not always safe and secure.

Other parts of the environment were not always safe. On the first day of the inspection the lift motor room door had not been kept locked. This was a potential hazard for those people who might enter it as it contained electrical equipment that could cause people injury. Another cupboard which contained

electrical panels which displayed a hazard sign had also been left open. We raised this with the acting manager who ensured that these areas were secured. On the second day of the inspection we found these areas to be secure.

During the inspection in November 2016 we identified that risk assessments around monitoring people's risk of malnutrition were not being completed appropriately, and action was not being taken to refer people to the dietician in a timely manner. During this inspection we looked at the malnutrition risk assessments for four people and found that three of these had been completed correctly. In one example the malnutrition risk assessment had not been completed correctly and had failed to identify a significant amount of weight-loss. Follow up by another member of staff 11 days later had identified this issue and ensured that the appropriate action was taken to refer this person to the GP and dietician as required.

At the last inspection in November 2016 we identified that audits of accidents and incidents were not being completed. During this inspection we found that accidents and incidents were being monitored. In some cases, the action taken to prevent incidents from reoccurring was effective, for example we identified a trend where there had been a higher concentration of falls between 3pm and 3:30pm in March 2017, which correlated to the break times taken by staff. This had been identified and addressed, resulting in a significant reduction in the number of falls. In other examples however we found that effective action had not been taken following incidents. For example the security of the premises had not been improved in response to an incident where a person had managed to abscond. In another example action had not been taken to review a person's needs after they had been found to have fallen down the side of their bed.

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

People were not always supported to take their medication as prescribed. We looked at medication records relating to two people whose prescription pain relief had not been reordered in a timely manner. In one example there had been a delay of 16 days before this was re-ordered and in another a delay of 11 days. In one example staff had documented that no pain relief had been administered because the medication was not in stock. Whilst staff had noticed this, they had not acted to re-order medication. We spoke to a member of staff who told us that one person had requested their pain relief because they were in pain and they had not been able to give this to them, because there had been none stock. This had left this person in pain, whilst their medication had been re-ordered for delivery later the same day. In another example the food supply for one person who required a liquid diet to be administered via a tube directly into their stomach, had not been re-ordered and had run out. This had resulted in this person going without their nutrition for a period of around 33 hours whilst this had been re-ordered.

Medication audits showed an ongoing variability in the actual amount of medication being stored compared to what should be in stock. An analysis of the reasons behind this had not been carried out. This meant that the registered provider could not be sure that people had received their medication as required.

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

We observed medication being administered by a member of staff, who did so appropriately. The member of staff used medication administration records (MARs) to ensure that the appropriate medicine was administered to people. The member of staff waited with people to ensure they had taken their medication as required before signing MARs to show this had been given. We looked at a sample of medication for three people to ensure that the correct quantities were being stored and found that they were. This showed that

some aspects of the medication administration and storage processes were working as they should.

At the last inspection in November 2016 we identified that the call bell system did not always work. During this inspection people told us, "They come when I press the call bell" and "I rarely press the call bell, but they have come quick when I have pressed it in the past". The nurse call system had last been tested in March 2017 to ensure it worked appropriately. We observed that the call bell system was functional and working as it should be at the time of this inspection visit. An audit of staff response times to the call bell system had been completed by the previous manager in February 2017 and March 2017 over a period of four days during each month. The results of these had shown that staff were responding within a reasonable time when people had pressed their call bell for assistance.

The acting manager told us that there had recently been a large number of staff leave the service. People commented on the high use of agency staff and told us that they got the support they needed, but did not always feel that agency staff knew what they were doing. Staff commented that at times staff sickness impacted upon staffing levels. At the time of the inspection visit we observed enough staff to meet people's needs. We reviewed staffing rotas and found that there were consistent numbers of staff in post each day. The acting manager told us that they were in the process of recruiting permanent staff.

Recruitment processes were robust and ensured that staff were of suitable character to work with vulnerable adults. New staff had been subject to a check by the Disclosure and Barring Service (DBS). This informs employers if any applicants are barred from working with specific groups of vulnerable people. New staff had also been required to provide two references, one of which needed to be from their most recent employer. This helped ensure that people were protected from the risk of harm.

Appropriate checks had been completed with regards to equipment and other aspects of the environment to ensure they were safe and in working order. For example maintenance records showed that hoists, slings and the lift had been serviced. There was a fire risk assessment in place and fire alarms were checked regularly. Electrical systems had been checked and portable appliance testing (PAT) had been carried out to ensure electrical equipment was safe. A check had been completed on the water supply to ensure it was free from harmful bacteria. This helped to ensure these aspects of the service were functioning safely and people were protected from harm.

Not all staff had completed training in safeguarding vulnerable adults. However they were aware of the different types of abuse and how to report their concerns. The registered provider had a safeguarding policy and procedure in place which staff were familiar with, and we saw positive examples where staff had taken action to raise their concerns. The registered manager sent a monthly update to the local authority with any concerns as required by the local authority's safeguarding procedure. We spoke to the acting manager about staff training who told us that this would be updated.

Staff had completed training in infection control and we observed examples where staff used personal protective equipment (PPE), such as disposable gloves and aprons prior to supporting people with their personal care. This helped ensure that people were protected from the risk of infection.

Requires Improvement

Is the service effective?

Our findings

People told us that they felt staff were good at their job. One person commented, "I'm looked after fantastically well. I had a rash all over my body and they got the doctor and nurses out to sort me out". Another person commented, "Generally staff are very good if you get permanent staff. Sometimes it's a bit hit and miss with the agency one".

At the last inspection in November 2016 we identified that staff had not always completed the training they needed to carry out their role effectively. At this inspection we found that training remained an issue. For example, seven staff had not completed training around promoting healthy skin, two of which had demonstrated very poor knowledge regarding this. 10 staff had not completed training around infection control or emergency procedures. Nine staff had not completed training in safeguarding, the Mental Capacity Act 2005 (MCA) and food safety. Medication administration competency assessments had also not been completed for two staff in charge of administering people's medicines.

At the inspection in November 2016 we identified that staff had not been receiving supervision due to changes in management. At this inspection, staff had still not received supervision. This was confirmed by one of the temporary managers. Supervision enables training and development needs to be discussed between staff and management. It also allows managers to discuss any performance related issues, and holds staff accountable for poor practice. It can also be used to recognise good examples of practice.

An induction process was in place for new staff which included a period of shadowing experienced members of staff, and undertaking training deemed to be mandatory by the registered provider, such as safeguarding and moving and handling . The induction process was aligned to the standards required by the Care Certificate which is a nationally recognised set of standards that care staff are required to meet. However, we looked at the training records for two new members of staff which stated that they had "failed to complete" training in areas such as safeguarding, infection control and equality and diversity by April 2017. At the time of the inspection this still had not been completed. This demonstrated that the registered provider had failed to ensure that new staff had the required skills and knowledge prior to starting in their role.

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

People commented positively on the food that was available. Their comments included, "The food is nice. I'm well fed", "The food is so nice" and "They offer seconds". Whilst people's comments were positive we found that one person had not been supported to have the diet they required, which could have resulted in a serious incident occurring. We also identified that information kept by kitchen staff around two people's dietary needs contained discrepancies or was incorrect. This placed people at risk of receiving a diet that was not appropriate to meet their needs and placed them at risk of harm.

There was sufficient food in stock for people using the service. The fridge and freezers were full of fresh and

frozen ingredients, and stock had been rotated to ensure this was all in date. Temperatures of fridges and freezers was being monitored on a daily basis to ensure that produce was kept at the correct temperature to stop it from spoiling. The kitchen was kept clean and tidy, and a cleaning schedule was in place to ensure this was maintained.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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, and found that in a majority of cases they were. In one example however, we identified where one person subject to a DoLS had managed to leave the premises without the required level of support. Where people required a DoLS an application had been made to put one in place as required.

People's care records contained details around their ability to consent to care, and whilst not all staff had completed training in the MCA, they had a basic understanding of their roles and responsibilities in relation to this. People commented that staff offered them choice, and we observed examples where this took place. For example, staff asked one person if they would like to spend time in their room, before supporting them to do so. We observed examples where they offered people a choice of drinks, and asked people how they preferred these.

In a majority of examples, people were referred to external health professionals as required. For example, people had been referred to their GP where they became unwell, or had been supported to access accident and emergency where required. In one example however we observed that one person had very long toe nails, and in another we identified a person who had not been referred to the dietician in a timely manner. We raised this with the manager to ensure they got the support they needed.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring towards them. Their comments included, "Staff are respectful", "I feel comfortable", "This is a nice place to live". People's family members also commented positively on staff. Their comments included, "Staff are nice" and "Yes staff are respectful". Whilst comments about staff were positive, we also observed examples of care that showed poor practice.

People's confidentiality was not always protected. Records containing personal information were being stored in offices that could be locked; however these were often left open whilst staff were not in attendance. This undermined the security of those records being kept. We raised this with the deputy manager for them to address. In other examples however we observed staff ensuring people's privacy was protected. For instance they ensured that doors remained closed when they were attending to people's personal care needs, and we also observed staff knocking before entering people's bedrooms.

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

In two examples we identified that people did not have access to their prescribed pain relief because this had not been re-ordered, even where this had been identified as being out-of-stock by staff. This placed people at unnecessary risk of being in pain. In another example a person had ran out of their nutritional supplement which had meant they had been left without food for approximately 33 hours. This did not show a caring attitude by staff towards the people in their care.

Throughout the inspection we observed a mixture of positive and not-so-positive examples of staff interactions with people. Staff were often task focussed in their approach, and we observed multiple examples where staff did not interact with people beyond those interactions relating to the care and support people needed. People were often left alone for prolonged periods of time with little or no interaction from staff. In one example a person told us they had been sat at the dining room table by themselves "for a while". We observed staff spending time in groups in communal areas chatting amongst themselves, rather than with the people in their care. We raised this with management so this could be addressed with staff.

Staff were kind and respectful when they engaged with people. For example we observed one person being supported to transfer from their arm chair into their wheel chair. Two staff supported this person, and both were patient and gave clear instruction and support when the person was struggling. In another example a member of staff offered reassurance to one person who called out for help, and brought them a cup of tea. After this the person seemed calmer and more settled.

People's family members told us that they were made to feel welcome by staff when they visited their relatives. Their comments included, "Staff offer us a drink when we come" and, "Yes I'm made to feel welcome". This meant that people could relax and spend time with family members, which supported them to sustain these important relationships.

Information about the local advocacy services was displayed on a notice board for people to access. This helped ensure that people could access support from an advocate if they needed to. Advocates ensure that people's wishes and feelings are adequately taken into consideration where decisions need to be made on their behalf. This helps ensure that people are involved in aspects of the care planning process.

Where people had chosen not to be resuscitated in the event of failing physical health, or where this had been decided in their best interests, this information was clearly displayed at the front of people's care records. This information was also on handover sheets so that staff could easily access this information in an emergency.

Requires Improvement

Is the service responsive?

Our findings

People commented that they found staff to be responsive to their needs. During the inspection people looked clean and well dressed. One person commented that staff usually knew what they were doing, but sometimes when agency staff were providing support they did not know the routine for using pressure relieving equipment. One person's family member told us that their relative "always" looked clean and tidy.

People each had a care record in place which contained information relating to how they needed to be supported. For example, with regards to their communication, personal care, physical and mental health. However, information contained within these records did not always reflect the care that was being provided. In one example a person's record stated that they required staff to use 'yes' and 'no' cards to support with their communication; however staff told us they did not use do this. Another person's care record stated that they required a normal mattress; however we observed that a pressure relieving mattress was now in place.

Daily monitoring charts were in place for those people who required support with altering their position for pressure relief, people with continence needs and people at high risk of malnutrition. However we found examples where these were not being maintained. In one example records for a person who required repositioning had no entries between the 23 May 2017 and the 5 June 2017 to show that this had been done. In another example a person's care record stated that they needed repositioning on a three hourly basis, however on 5, 6 and 8 June 2017 there were no further entries to show this had been done after 19:00 hours. We raised this with the manager who was aware that this was an issue within the service, and that efforts were underway to try and improve this.

Reviews of people's care records were being carried out, however due to the issues identified this showed that this process was not always effective. In one example incident records showed that one person had fallen down the side of their bed during the night. Despite this a review of the bed rail risk assessment had not taken place to ensure that bedrails were still not required. We raised this with the manager for them to review.

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

People's care records contained details relating to their likes, dislikes and life history. For example, one person's care record gave an account of their close family relationships. Another person's care record outlined how many sugars they liked in their tea, and what food they liked to eat. This ensured that staff had information available which could help them get to know the people they were supporting, and facilitate the development of positive relationships.

There were activities in place for people; however some people commented that they sometimes felt "bored". On the day of the inspection there were no activities in place for people. We observed people sat in communal areas and watching television without any meaningful interaction from staff for extended

periods of time. There was an activities rota in place, however people told us that this was not always followed. Activities records showed that there had been activities such as singers, bingo, group and one to one activities within the service. One person commented that the church sometimes visited and carried out a service.

There was a complaints process in place for people and their family members however a copy of the complaints policy was not on display and available for people using the service. We asked the manager to ensure that a copy of this was made accessible to people so they could express their concerns where needed. Where a complaint had been made, a response had been given to the complainant in a timely manner. This showed that the registered provider was responding to complaints appropriately.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post within the service. The previous registered manager had left the service In April 2017. People we spoke with did not know who the manager was, and were unaware of the change in the management structure. For example one person and their family member named the previous manager as a point of contact to raise any concerns with. However, following the inspection the registered provider provided evidence which showed they had made attempts to keep people and their relatives updated on management changes within the service. On the first day of the inspection the deputy manager was acting as manager. On the second day of the inspection there was an interim manager in post, along with a manager from another service.

At the last inspection in November 2016 we identified that systems were not sufficient to ensure the safety and quality of the service being provided. At this inspection we found that whilst some improvements had been made these systems were not always effective.

At the last inspection in November 2016 it was identified that audits were not being completed to ensure the quality of the service was being maintained. At this inspection we found that whilst these were being completed, these were not effective. For example medicines audits showed that there were regularly variances in the stock levels that should be stored compared to what was actually being stored. Audit systems had failed to adequately explore the reasons behind this. For example, the audits around stock variances contained comments such as, "? Correct dosage not given", "? Not recorded correctly" and, "Not sure why". This meant that the registered provider could not accurately determine whether people had received their medication as prescribed. We raised this with the acting manager for them to address.

An investigation had not been completed in a timely manner in response to an incident that had occurred within the service, and appropriate follow up action had not been taken. This had led to this incident reoccurring, which demonstrated a failure to take preventative action to act on known risks. During the inspection visit we asked that an internal investigation was completed. This was carried out as required. This investigation report was comprehensive and contained appropriate actions to prevent the issue from occurring again.

In June 2017 there were two examples where staff had not been aware of people's dietary needs. In one case staff had provided a service user with inappropriate foods. This had resulted in the person choking. The second incident had occurred nine days after the initial incident where it was also recorded that a person had been provided with inappropriate foods. We have asked for a full investigation of this issue. In addition, audits of information relating to people's dietary requirements had failed to identify that information kept in the kitchen about people's dietary needs was not always correct.

During the inspection we identified issues relating to the reordering of medication and one person's nutritional supplement. This had resulted in two examples where people had been left without their pain relief for extended period of time, and one person being left without food for approximately 33 hours. Whilst issues relating to the re-ordering of medication and other prescription items had been identified as an issue

by the registered provider, at the time of the inspection effective measures had not been implemented. We raised this with the manager who told us that a person was going to be put in charge of managing re-ordering of medicines.

Audit records showed that around 14 per cent of care records were audited each month, which, based on the occupancy levels at the time of the inspection visit, meant that each care plan would be audited every eight to nine months. This was not sufficient to identify any issues that may occur in a timely manner. This had resulted in care records not always containing accurate and up-to-date information.

The registered provider had completed a quality monitoring check in February 2017, and the area director had also completed a visit to the service in March 2017. These had identified a number of issues within the service in relation to areas such as staff morale, medication, and training in safeguarding and infection control. At the time of the inspection we identified that these concerns still remained an issue. This demonstrated a lack of adequate leadership within the service to make the improvements required. Following the inspection the registered provider appointed a turn-around manager to support the service with making the required improvements.

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

The registered provider is required by law to notify the CQC of specific events that occur within the service. During the inspection visit we identified two examples where this had not been done. After we raised this with the manager these were submitted by the registered provider. This meant that the registered provider was not acting to fulfil their lawful obligations.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the last inspection in February 2017 we made a recommendation that the registered provider look at ways of improving their methods of gaining feedback from people using the service, their family members, professionals and staff. During this inspection we found that action had been taken to address this. A meeting had been held with people and their family members in June 2017 during which an update on the service had been provided to them, and they had been able to ask questions. The registered provider had also sent out a survey to people and their family members, however the results of this were not yet available. On the first day of the inspection the electronic feedback point was not in use, however this had been rectified on the second day.

Staff told us they felt supported by the acting manager; however they also commented that the high turn-over of management was "demoralising". A majority of staff we spoke with felt that staff morale was low, which they attributed to increased levels of staff sickness and the increased use of agency staff. Two members of staff also commented that they did not feel comfortable with reporting concerns to outside agencies, as per the registered provider's whistleblowing policy, due to a fear of losing their jobs. This demonstrated a poor dynamic between the registered provider and staff working at the service.

The registered provider is required by law to display the rating of the previous inspection in the service as well as on their website. We checked that this was being done and found that it was.