HC-One Limited

Falstone Manor

Inspection report

Cliffe Park
Whitburn Road, Roker
Sunderland
Tyne and Wear
SR6 9NQ

Tel: 01915496699
Website: www.hc-one.co.uk/homes/falstone-manor

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 4 and 12 September 2017 and was unannounced. We previously inspected the service on 17 and 23 March 2016 and found the service met the regulations we inspected against at that time. The service was rated as 'good' overall with each domain being rated as 'good'. During this inspection we found the provider had breached the regulations in relation to staffing and good governance.

Falstone Manor is a three storey home that provides personal care, nursing care and support for up to 51 people, some of whom are living with dementia. At the time of the inspection there were 45 people using the service.

The home did not have a registered manager. The manager registered with CQC had left in August 2016. Since this date there had been at least three temporary managers in post. In order to stabilise management arrangements at the home the provider had been proactive in arranging for an experienced registered manager from an adjoining home to provide leadership to Falstone Manor. At the time of this inspection this situation was under review and due to be evaluated to assess the potential outcome on the home and people using the service. 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.

This inspection was triggered due to a number of concerns we received about inadequate staffing levels. These included people having to wait considerable periods of time for assistance; people being left unsupervised in communal areas; people left in bed or put to bed early due to a lack of staff and no personalisation or choice. Although we did not find evidence that people were put to bed early, we observed some examples of the other concerns raised with us. For example, we saw
people were often left unsupervised in communal areas, sometimes for significant periods of time. People and relatives gave us positive feedback about the caring nature of the staff providing their care, however they told us due to staff shortages they did not always receive the personalised care they required. We also saw examples of people having to wait a considerable amount of time for assistance.

Without exception people, relatives and staff told us staffing levels at the home were insufficient to meet people's needs appropriately. People described to us how they often had to wait for assistance. Staff members confirmed they were unable to help people in a timely manner. People, relatives and staff had consistently raised concerns about staffing levels since January 2017. Following out inspection the provider confirmed that people's dependency levels and staffing levels were regularly reviewed. The provider us with a copy of the most recent review and details of a plan to trial a change to how staff were deployed in the home.

People and staff told us there had been numerous temporary managers and a lack of leadership to make improvements to the care provided at the home.

Staff members were not receiving regular supervisions and appraisals. Some staff said they did not always feel supported, particularly in relation to staffing levels. Moving and assisting training was overdue for some staff.

Some care records were inaccurate. Although people's care plans were in the process of being updated, progress to date had been limited. Periodic reviews of people's care were also overdue for most people.

You can see what action we told the provider to take at the back of the full version of the report.

Safeguarding concerns were dealt with effectively with appropriate referrals made to the local authority safeguarding team. Staff had been trained in safeguarding and had a good understanding of safeguarding and the provider's whistle blowing procedure.

Medicines were stored and administered safely. Staff had received the training they needed and medicines records were completed accurately.

There was a system of health and safety checks to help ensure the building and equipment were safe for people, such as checks of fire safety, water systems and specialist equipment. The provider had developed plans to deal with unforeseen incidents or emergencies. Personal emergency evacuation plans (PEEPs) had been written which described people's support needs in an emergency situation.

Accidents and incidents were recorded and monitored. Reviews were carried out to check the correct action had been taken and to identify patterns or trends.

The provider had effective recruitment procedures in place to ensure the safe recruitment of staff. This included pre-employment checks to assess the suitability of new staff before they started working at the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed people were supported to have enough to eat and drink in line with their needs. Where people required support or specialist equipment this was provided.

Care plans were in the process of being reviewed and updated. At the time of our inspection this review had not yet been completed.

Organised group activities were provided each day, however people in communal areas often lacked engagement and stimulation.

People and relatives knew how to complain if they were unhappy with the care provided at the home. Previous complaints had been logged and investigated.

There were opportunities for people, relatives and staff to share their views about the service.

The manger and deputy manager had implemented the provider's quality assurance system and regular audits were being completed.

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.

People, relatives and staff told us staffing levels were not sufficient to meet the needs of people living at the home.

We observed people were often left unsupervised in communal areas for long periods of time.

Medicines were managed safely.

There were a range of health and safety checks in place as well as procedures to deal with emergency situations.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive regular one to one supervision or an annual appraisal. Moving and assisting training was overdue for some staff.

The provider followed the requirements of the Mental Capacity Act 2005.

People were supported to meet their nutritional and health care needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they did not have regular one to one time with staff.

People and relatives said staff members were kind and caring.

When staff supported people they treated them with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always respond to people's needs in a timely manner.

Care plans required further development to ensure they accurately reflected people's needs.

Activities were available for people to take part in.

People knew how to complain but told us they felt the provider did not always listen to their concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People and staff felt regular changes of management had impacted negatively on the quality of their care.

The provider had been proactive in taking action to stabilise management arrangements at the home.

We received information from the provider to show dependency levels and staffing levels had been reviewed.

Care records were not always an accurate reflection of the care people needed and the care they had actually received.

The manager and deputy manager had implemented the provider's quality assurance system.

Falstone Manor

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.

We undertook this inspection on 4 and 12 September 2017 in response to a number of concerns we had received about the service regarding inadequate staffing levels. The first day of our inspection was unannounced and carried out by an inspector 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. On 12 September 2017 the inspection was carried out by one inspector.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. As this inspection was brought forward we had not sent a Provider Information Return (PIR) to complete. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. Healthwatch is the national consumer champion for health and care.

During the inspection we spoke with five people who used the service and three relatives. We also spoke with the area director, the manager, the deputy manager, four nurses and five care staff. We looked at care records for four people as well as medicines records. We looked at a range of other records which included recruitment records for five staff members and other records relating to the management, quality and safety of the service.

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.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service 16 people were living on the ground floor of the home. Daytime staffing levels were one qualified nurse and three care assistants. On a night-time this reduced to one qualified nurse and one care assistant. 14 people were living on the first floor of the home. Daytime staffing levels were one qualified nurse and three care assistants. On a night-time this reduced to one qualified nurse and one care assistant. 15 people were living on the second floor of the home. Daytime staffing levels were one of either a qualified nurse, a nursing assistant or a senior care assistant and two care assistants. On a night-time this reduced to two care assistants.

We discussed with staff members the level of support people needed and the deployment of staff. They told us the ground floor of the home was particularly demanding due to the complex needs of the people living at the home. Staff told us all 16 people required two to one support from staff members. The range of needs included four people requiring a Percutaneous Endoscopic Gastrostomy (PEG) feed, people who were insulin dependent and one person receiving end of life care. A PEG is a feeding tube which passes directly into the stomach so that food, water and medication can be given without swallowing. One staff member told us, "At the moment it is quite heavy [workload]. It is a very heavy unit. I don't think we can give them the care, we can't spend time with people. We should be able to spend time with people."

People, relatives and staff we spoke with during the inspection consistently told us staffing levels were not appropriate to meet the needs of people using the service. People gave us numerous examples of situations where they had required assistance from staff but had to wait because they were too busy. This included having to wait to be assisted with dressing and to go to the toilet.

People commented: "I pressed the buzzer and they didn't come for ages. I normally have to wait a long time before they answer my buzzer, it took one hour and 20 minutes last night to get it answered, I do know when they're busy I have to wait I know that"; "On Saturday [2/9/17] there was only two carers and the nurse on duty had someone shadowing her. This floor has a lot of people who need feeding and need two carers to get people ready as most need hoists. It affects me as everything is late, they work 12 hour shifts and they don't get any breaks on time. It's happened before especially when someone's on the sick, they get a lot of agency nurses now and they don't have time to meet [get to know] the residents"; "Sometimes it can be low and on Saturday [2 September 2017] there were two carers and one nurse on the floor and the nurse was training someone so she couldn't really help, she has nursing duties so can't really help with the care work so I couldn't get to the toilet because I need two to help take me I was a bit cheesed off. It happens most weekends quite a lot on a Saturday and they haven't got bank staff, they have rotas so they should know about this, it's disgusting they shouldn't get away with this"; and, "I think they could do with more [staff]. They who work here, they're very diligent and work very hard. It would be nice to have a five minute chat and for their sakes too, it's hard going and physical for them especially when the place is full there's lots of work, it's difficult. We know they're busy, it's purely on a social level."

Similarly relatives had concerns about staffing levels. One relative told us, "They work really hard, I think they should have four on this floor as by lunchtime they're exhausted. There's normally three but many

residents rely on the staff and it sounds awful but if someone rings in sick they're then down to two. The staff are lovely just sometimes I look at them and they look so worn out." Another relative commented, "The staffing levels are not appropriate there should be a full time nurse on this floor I spoke to the previous manager during a review of my [relative] and told him you need more staff. The weekends are worse there was only two on yesterday."

Staff members commented: "A lot of the time we are short [staffed]"; "Staffing levels are a concern. We were short on Saturday and Sunday. That is a concern because if anyone took poorly and had to go to hospital it is one member of staff off the floor"; "There are certain residents on some floors who try to be independent and because of staff shortages it is unsafe due to the level of staff"; and, "There isn't enough [staff], everyone is a two (person requires support from two staff)."

We observed people, some of whom had been assessed as being at risk of falling, were often left unsupervised for long periods in communal areas. For example, we carried out a specific observation in the ground floor lounge. When we entered the lounge there were four people sitting with no staff members present. After 10 minutes the deputy manager walked past the communal lounge. We noted staff members then entered the lounge and began interacting with the people present. Staff members later told us they had been instructed to go into the lounge but this meant other people in their rooms had to wait for assistance.

Care staff including qualified nurses raised concerns with us about the accuracy and effectiveness of the dependency tool the provider used to determine staffing levels in the home. We attended a handover meeting to assess how well information was communicated when staff members started and ended their shifts. Staffing levels were discussed in the handover meeting and in particular the dependency tool the provider used to determine staffing levels. One staff member commented, "The dependency levels aren't assessed properly. I don't know what tool they use." We also spoke with staff members individually. One staff member commented, "The dependency tool is not adequate. It doesn't reflect at all the full dependency of these people. Especially down on the ground floor."

We discussed staffing levels with the manager and deputy manager. They did not identify any concerns with the current staffing levels. The manager told us a dependency tool was used to determine staffing levels. They said this was reviewed regularly and showed that the actual number of staff deployed was greater than the number recommended by the tool. They went on to tell us the dependency levels were assessed by the care team. The manager confirmed qualified nurses were included in the number of care staff and were expected to deliver care and support the care staff. They also told us people did not always recognise the input from nurses in delivering care. However, care staff told us the nursing staff were often unable to provide assistance as expected as they were also extremely busy.

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

Although staff raised concerns about staffing levels, most staff still felt people were safe living at the home. Staff knew about the provider's whistle blowing procedure and said they would definitely use it if they were concerned people were not safe.

When we last inspected the home we noted the provider dealt with safeguarding matters appropriately. We found this continued to be the case. Where required safeguarding concerns had been referred to the local authority safeguarding team and an investigation carried out. Records confirmed staff had completed training to develop their knowledge and understanding of how to respond to safeguarding concerns.

Medicines were usually managed safely. Medicines administration records (MARs) accurately accounted for the medicines people had received. Where medicines had not been given a non-administration code was input onto MARs to show the reason for this. Other records showed medicines were received, stored and disposed of effectively including medicines liable to misuse (controlled drugs). Nurses and other senior care staff had completed relevant medicines management training and had been assessed as competent to administer medicines.

The provider carried out a range of checks to help ensure equipment and safety devices used at the home were properly maintained and safe to use. This included checks of fire equipment, water systems, hoists and electrical items. We viewed up to date certificates showing the gas and electrical safety systems had been checked and were satisfactory. A Fire Risk Assessment had been carried out in February 2017. A number of actions had been identified and associated records showed these actions had been completed.

There were plans in place to deal with emergencies and unforeseen incidents. People had personal evacuation plans (PEEPs) which identified their mobility needs and described the support people needed in an emergency situation.

Accidents and incidents were appropriately recorded and monitored. Records were available of each accident and the action taken to keep people safe. Incidents and accidents were analysed periodically to identify any patterns or trends.

There were effective recruitment processes in place to ensure new staff were suitable to work with people living at the home. We viewed records which showed pre-employment checks had been completed before new staff started their employment, such as taking up references and completing a Disclosure and Barring Service (DBS) check. These checks were carried out to ensure prospective staff did not have any criminal convictions that may prevent them from working with people.

The home was well maintained and was clean and tidy.

Requires Improvement

Is the service effective?

Our findings

At the time of our inspection staff members did not have the opportunity to have a one to one supervision with their manager to discuss their role and personal development. We viewed the most recent records available and found appraisals were overdue for all staff. With regards to supervisions the records confirmed these were overdue for 17 out of 22 staff. For one staff member their last recorded supervision was May 2016. For a further four staff the records stated their supervision was overdue and that they had not previously had a one to one supervision. One staff member said, "Since January I have only had one [supervision]." Another staff member commented "not really" when we asked if they had regular supervision with their line manager. Following our inspection visits the manager provided information to show all staff had now received a supervision session.

The provider had designated certain training courses as essential for staff members. This included moving and assisting, food safety, infection control, safeguarding and equality and diversity. Although most staff had completed these training courses, we found from viewing the provider's training matrix that moving and assisting was overdue for 33% of staff.

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

Although regular one to one supervisions were not taking place, staff members told us they could speak to the manager if they needed to. One staff member said, "You can go and talk to them [management]." Another staff member commented, "Support is better now with [deputy manager] and [manager]. I know if I have any problem I can go to them." A third staff member told us, "If I had issues I could speak to them, they have an open door policy."

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. Where people lacked capacity, DoLS authorisations had either been applied for or were authorised. The provider had effective systems to ensure DoLS authorisations were reviewed when required.

We observed over the lunchtime to assess people's dining experience. We saw that people were usually

supported in line with their needs. The dining rooms were set with tablecloths and placemats in advance of people arriving to have their meal. The environment was relaxed with background music playing. Where people required assistance this was provided appropriately. For example, we saw one staff member explained to a person what the dessert was that she was eating. We also saw the staff member cutting up the meal for the person and encouraging them to try it. We overheard another staff member say to a person, "Come on and get your dinner flower, use your knife and fork." They went on to say, "Your potatoes look a bit too big I'll cut them up small for you." Where people required specialist equipment to aid eating this was provided, such as food guards and adapted cups or beakers. We noted people were offered different choices of desserts. For instance, some people were offered peaches and ice-cream only, whereas other people were also offered this as well as yoghurt and rice pudding. We discussed this with the manager who was uncertain why this would be the case.

People were supported to meet their health care needs. Care records showed people had regular involvement from healthcare professionals when required. One person said, "Any hospital appointments my [relative] normally goes with me otherwise if a carer needs to go then that's more staff taken off the floor."

Requires Improvement

Is the service caring?

Our findings

Some people who used the service said they didn't have regular opportunities to have one to one time with staff. They also commented their care was often rushed as staff were so busy. People commented: "Just when you're getting ready they chat to you and I have a laugh with them. They should be able to have time to have a cup of tea with you but they don't"; "It is awkward in the mornings, better in the afternoons and [staff member] is marvellous and always around but it's tricky for them and a bit more time would be nice. It's difficult as some residents take more time to look after than others, the girls are lovely"; "It's rushed so they can get to the next person but I can dress myself, my top half and I can brush my teeth myself"; and, "When they come in to give me my tablets they're out the door in no time." One relative told us their family member required support from staff regularly throughout the day. They told us, "[Family member] has to be turned every hour or so and changed, the only thing is [family member] needs changing and many many times. They tell me we'll have to wait as they're busy."

We observed people were often left unsupervised in communal areas with little interaction from staff. During the 30 minutes of one of our observations we saw there were no care staff present throughout this time. Some people in the lounge lacked the ability to mobilise independently. At one point a person [male] entered the lounge in a wheel chair. The person approached us as they said they had been waiting for over half an hour for some assistance with dressing. We noted the person did not have any clothes on their top half. The deputy manager intervened and offered assistance.

Most people told us the staff were kind and caring. People commented: "They're very good and nice. I wouldn't say anything wrong about that, they work very hard"; "There's been a few instances when I've become ill in here …I always feel very well looked after. I'm not a very good eater and they try to encourage me." One relative said, "They love [my relative] and they interact with her. Another relative told us, "I come in to visit six days a week …I've seen my relative come a long way since he came in here with the support from the staff and the nurses."

Although people told us they felt their care sometimes felt hurried, they commented when staff supported them they were treated with dignity and respect. One person told us, "They talk to me by name and help to get things for me." Another person said, "They close the door if everyone's around, they respect my privacy." One relative commented, "I've seen that they protect [family member's] dignity. They keep him covered when he's getting washed and they knock before entering and close the curtains." Another relative said, "Very caring. They see that [person] is nice and tidy, I never come in and see her with her pyjamas on. I'm not allowed in when they're doing personal care I have to wait outside and there's always two of them. A third relative told us, "They tell [family member] exactly what they're going to do when they get him up. They tell him they'll hoist him and give him his breakfast. They explain they're going to wash him and things like that and not just with my [family member] I've heard them explaining to other residents."

People were able to be as independent as possible. One person said, "I have [flower] pots in the garden and I go out and water them, there's no restrictions like that." Another person told us, "I make my own decisions, I can get around the home on my own." A third person commented, "I went out for lunch with a friend the

other day and we had a walk around the park." One relative told us, "Sometimes [family member] is able to maintain his independence. [Family member] can choose when he wants to go to bed. Sometimes staff will ask him if he wants to get up or stay in bed and I take him to the activities."

Requires Improvement

Is the service responsive?

Our findings

People told us staff were not always quick to respond to their needs. One person told us they were waiting for someone to look at their TV as it had no signal and they had reported this two days earlier. Another person said they had asked staff for a bowl and had been waiting for 35 minutes. They went on to say, "Last night I rang the buzzer and it took 20 minutes [for staff to respond]."

People had a range of care plans in place describing their needs and the support they required to meet these needs. These covered a range of areas including personal care, medicines, communication and skin integrity. Care plans contained some information about peoples' preferences such as their likes and dislikes. Care plans had been reviewed on a regular basis by senior staff. However, we could not be certain they accurately reflected people's individual needs as we found examples of inaccurate information within care records. For example, contradictory information about people's dietary and skin care needs. We noted the provider had already implemented a plan to fully review and update every person's care records. This work was on-going and progressing at the time of our inspection.

People and relatives told us there were activities available for them to participate in. One person said, "They do bingo and we had a cheese and wine event and a Spanish evening. We used to go out to places like the Hancock museum to see the Lindisfarne Gospels and Preston Park, Teesside but they don't do these now it's been a couple of years since." Another person commented, "Bingo, card making, baking, quizzes, and we go out for coffee sometimes. A third person told us, "I do tapestries and watch TV and I do garden planning." One relative said, "They can take six residents out at a time. The activities coordinator will ask the residents where they want to go. On Fridays they have bingo and there are themed events. They just do different themes each week. The Activities Coordinator will ask the residents what they want." Another relative said, "They do different things this afternoon it's card making and they've just started a book club."

The home had a dedicated well-being co-ordinator. We observed when we inspected there were organised activities for people to attend. For example, on the first day of our inspection an arts and crafts session had been organised for the afternoon.

Most people and relatives knew how to make a complaint if they were unhappy with their care. One person said, "I would go to the manager." One relative told us, "If it was medical it would be the nursing staff or if it's something different I suppose it would be the manager, if I couldn't talk to the carers I would go to [manager's name], she's really good. I have no concerns whatsoever [family member] likes being here." However, some people felt their concerns were not taken seriously by the provider or management. One person said, "Yes I do know [how to complain] but sometimes they don't listen and sometimes I find when [my relative] complains then it gets dealt with, sometimes I think as a resident I get ignored and [my relative] has more clout than me." Another person commented, "Sometimes they do listen but not always. We mention things in the meetings and they don't get done, about staffing levels mostly."

The provider's complaint log showed 10 complaints had been received between April 2017 and August 2017 covering a range of issues including: communication, lack of information, lack of leadership and lack of

response from staff when pressing the nurse call. Records confirmed all complaints had been investigated and a response sent to the complainant. Action taken to resolve complaints included issuing apologies, providing explanations, updating care documents, one to one meetings with managers and reviewing care practice.

Requires Improvement

Is the service well-led?

Our findings

Concerns about staffing levels and management of the home had been raised in various forms since January 2017. We viewed the feedback from a recent consultation with residents and relatives. Although there was some positive feedback received, staffing levels and the management of the home were raised as a concern. One relative had described that in the short time their relative had lived in the home there had been 'several managers' and that they were 'worried about night staff'. They went on to state they had raised concerns 'several times with poor outcome'. Another relative commented they were unable to name the manager as they were 'constantly changing' and 'short term'. A third relative commented that managers were 'never in post long enough to make a difference'.

Staffing levels were also a theme at both residents' meetings and staff meetings. For example, minutes confirmed relatives had raised concerns in meetings held in February, July and August 2017. Staff had also raised similar issues in the most recent staff meeting in August 2017. Staff commented they did not always feel listened to when they raised issues about staffing levels. One staff member said, "If we are short staffed we get told tough, just get on with it." Another staff member said, "They just say that this is fine [in terms of staffing levels], that's all we ever get."

People told us they had raised their concerns at residents' meetings but nothing had changed. One person said, "We often do [raise concerns], I do and [relative] does. We raise this at residents' meetings but nothing seems to get done. Everyone agrees they need more staff on the ground floor definitely, we raise that at every meeting and most of the relatives do" Another person commented, "They've done nothing [to improve the situation]."

We discussed these concerns with the newly appointed area director, who told us they had not been made aware of issues with staffing levels. Following our first day of inspection dependency levels were re-calculated. The outcome of the review was that more staff were being deployed than the dependency tool recommended. The area manager also told us that where there were complex needs or concerns about the staffing within a service a more detailed review was carried out. They said this involved a review of information collected at the home as well as key clinical indicators, the clinical risk register and information directly relating to the specific needs of some people. Despite these on-going concerns about staffing levels we found no evidence that this more in-depth review had been undertaken to address people's concerns, other than the regular review of dependency levels.

The home did not have a registered manager. The home had been through an unsettled period due to a lack of consistent management and leadership. There had been a number of interim managers appointed. In order to improve the situation the manager from a sister home was managing both homes with support from a deputy manager in each home. This arrangement was to be reviewed on 21 September 2017 with the intention of agreeing more permanent management arrangements moving forward.

Care records we viewed were not always accurate. Some people required an air flow mattress to protect them from developing skin damage. The correct setting for these mattresses was based on each person's

weight. However, care records we viewed for four people included contradictory information about how much they weighed. For example, one person had different weights recorded in their weight records, nutritional assessment and mattress check records. This meant it was difficult to establish whether the mattresses were set correctly. A nurse adjusted people's mattresses whilst we were present to ensure they were set correctly. A nurse in another person's care plan stated they required a high protein diet. However, a care summary stated they did not have any specific dietary needs and required a 'normal diet'. We also found gaps in records for topical applications such as creams and ointments.

The format for fluid balance charts prompted staff to record a daily target for people's fluid intake to help ensure they were appropriately hydrated and to document whether people had achieved this target. We found on all charts we viewed this information was not recorded. This meant it was difficult to assess people's fluid intake and whether any additional action was needed.

The manager and deputy manager were aware care records needed improving. A plan was in place to audit each person's care plans to ensure they were accurate and up to date. Care plans were being audited by the management team as they wanted to be sure they were reviewed consistently. However, we noted progress to date had not met the expected number of care plans to be reviewed each month due to the other demands placed on the manager and deputy manager. We also found periodic reviews of people's care were overdue. We viewed a matrix which identified whether people required a three or six monthly review of their care. The matrix confirmed that 34 out of 43 reviews had not yet been completed.

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

Staff we spoke with were more optimistic now about the future of the home. One staff member said, "When you haven't got leadership staff morale is low. [Deputy manager] and [manager] have a lot on their plate. They have made slight improvements. There is a little bit more structure."

Staff told us, other than in relation to staffing levels, the manager and deputy manager were approachable. One staff member said, "Support is better now with [deputy manager] and [manager]. Prior to that managers were coming and going." Another staff member said, "It has improved since [manager] and [deputy manager] are both here. They seem approachable." A third staff member said, "[Deputy manager] is definitely approachable."

The provider had a structured approach to quality assurance called 'Cornerstone.' The manager told us prior to them taking over management of the home the Cornerstone system had not been fully implemented at the service. We saw from the beginning of August the system was being fully utilised and the required checks and audits were now in place. This included checks of health and safety, incidents and accidents, medicines, safeguarding, complaints and compliments. However, at the time of this inspection it was too early to assess how effective this system will be in driving forward sustained improvement in quality. Managers carried out a 'daily walk around' of the home and 'flash meetings' with key staff to check on specific areas of people's care and welfare.

The provider's own quality inspector had completed a comprehensive inspection of the home in May 2017. This was a usually a bi-monthly inspection and due to be carried out again imminently. The format of the inspection followed the five CQC domains of safe; effective; caring; responsive and well led. The overall rating given to the home was requires improvement and an action plan had been developed following the inspection. Actions identified including checking the status of DoLS authorisations, a review of people's dining experience and improvements to communication. Where actions had been completed we noted the

action plan had been updated to reflect this.

The provider had a system called 'You said, we did' which was used to advertise the action taken in response to people's or relatives' feedback and suggestions. For example, we noted the latest information on display related to the constant change in management. The action recorded as having been taken was the deputy manager now in post, a night shift manager appointed and a general manager to take responsibility for the running of the home.

There had been six compliments received between January and June 2017 about the care provided at the home. Words used to describe the home included: 'great kindness and respect; 'cheerful and responsive staff'; and, 'care staff are a credit to the company'.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems to assess, monitor and improve the quality and safety of the care people received. Action had not always been taken to mitigate risks to people using the service. The provider did not always keep accurate records in relation to people using the service. Regulation 17(2)(a); 17(2)(b) and 17(2)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to meet the needs of people. Staff did not receive the support and training they needed to enable then to carry out their role effectively. Regulation 18(1) and 18(2)(a).