Hallmark Care Homes (Leigh-On-Sea) Limited

Admiral Court

Inspection report

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29 April 2016
06 May 2016

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Admiral Court provides care and accommodation for up to 60 people split over two units Amazon and Swallow. The inspection took place on the 28 April 2016, 29 April 2016 and 06 May 2016. The home is registered to provide a service to older people, younger adults and people with sensory impairments, mental health conditions and dementia, at the time of our inspection there was 60 people living in the service

The home had a registered manager in place. 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.

People's needs were being met. Although our observations showed that staff deployment throughout this inspection was good, staffing levels at weekends were not always maintained to the level of week days which was also reported to us by staff and confirmed in rotas we reviewed.

Although staff knew how to recognise and respond to abuse correctly, not all people felt safe and we found that the arrangements to keep people safe were not robust. Individual risks had not always been assessed and identified. Arrangements were in place to ensure that staff had been recruited safely and received opportunities for training, however not all staff had received regular supervision.

Opportunities for people to engage in social activities were variable, particularly for people who were immobile and/or remained in bed so improvements were required and this was the case at our previous inspection. Some people and their relatives did not feel involved in the care they received however improvement had been made since our last inspection.

There was a system in place to deal with people's comments and complaints however we found that the registered manager had not investigated, recorded and dealt with complaints in line with the provider's policies and procedures. We also found the Registered Manager had limited insight on complaints that had been dealt with or resolved.

Whilst we were concerned that some staff did not always recognise poor practice, suitable arrangements were in place to respond appropriately where an allegation of abuse had been made.

Arrangements in place to keep the provider up to date with what was happening in the service were not always effective. As a result there was a lack of positive leadership and managerial oversight. The Registered Manager had failed to use the systems put in place to identify and monitor the safety and quality of the service as they had failed to recognise the shortfalls or when they did there was a lack of action to rectify them.

People had sufficient amounts to eat and drink to ensure that their dietary and nutritional needs were met. People and relatives told us that staff treated people with kindness and were caring. Staff knew the needs of the people they supported. We found that people were always treated with respect and dignity and people received good care.

The Registered Manager had knowledge of the recent changes to the law regarding Deprivation of Liberty Safeguards (DOLS) and was also aware of how and when to make a referral if required. People were safeguarded from harm. Staff had received training in Mental Capacity Act (MCA) 2005 and had knowledge of Deprivation of Liberty Safeguards (DoLS).

As part of our inspection we met with the provider's representatives who told us how they planned to bring improvements to the service and in terms of people's care delivery.

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 were not always protected against the risks associated with medicines because the Registered Manager did not have appropriate arrangements in place to manage medicines safely.

Not all people felt safe and there were not always effective systems in place to reduce the risk and spread of infection.

The recruitment process was robust which helped make sure staff were safe to work with vulnerable people. The deployment of staff was not appropriate to meet the needs of people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service.

People had sufficient food and drink and experienced positive outcomes regarding their healthcare needs.

Is the service caring?

Good

The service was caring.

Staff treated people kindly and respected people's privacy. People's care plans that detailed their preferences of care, including their past life history.

We found staff be knowledgeable of people's individual care. People were offered choice in their daily lives.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People were not always engaged in meaningful activities and

supported to pursue pastimes that interested them, particularly for people living with dementia.

Not all people's care records were sufficiently detailed or accurate.

Arrangements were in place for the management of complaints however they had not proved effective.

Staff were not consistently responsive to people's needs.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a lack of managerial oversight of the service as a whole.

The quality assurance system was not effective because it had not identified the areas of concern and there were no plans in place to address them.

Personal records were stored in a locked office when not in use.

Admiral Court

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 Registered Manager 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 the 28, 29 April 2016 and 06 May 2016 and was unannounced. The inspection was undertaken by three inspectors, Expert by Experience and Specialist Advisor on the 28 April 2016 and two inspectors on the 29 April 2016 and 06 May 2016. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service including previous reports and notifications. We also reviewed safeguarding alerts and information received from a local authority and other Commissioners. Notifications are important events that the service has to let the Care Quality Commission know about by law. We use this information to plan what areas we were going to focus on during our inspection.

As part of the inspection we spoke with 27 people who used the service, 10 relatives, 15 members of care and support team, Regional Clinical Manager and the Registered Manager. And prior to the inspection we also spoke with one social care professional, Dementia nurse and Continuing Health Care nurse(CHC).

Some people were unable to communicate with us verbally or to tell us about the service and how they were cared for. We therefore used observations, speaking with staff, and relatives, reviewing care records and other information to help us assess how people's care needs were being met.

As part of this inspection we reviewed 12 people's care records. We looked at the recruitment and support records for three members of staff. We reviewed other records such as complaints and compliments information, quality monitoring and audit information and maintenance records and also the electronic medication system and records.

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

Although intuitively staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers, this was inconsistently applied. Additionally where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

Staff told us that one person could place others at risk by trying to assist others who were unable to mobilise to stand, to enter others room and switch off essential equipment and to attempt to give food to those who had eating and swallowing difficulties. Although a risk assessment was in place this had not been reviewed or updated since 20 January 2016. We found that since 20 January 2016, there had been nine occasions whereby this person had placed others at risk of harm. For example, by trying to assist people to mobilise out of their chair or bed, attempting to give one person a drink that had not been thickened and which placed them at risk of choking and two occasions whereby they had turned off vital equipment. Although actions to mitigate the risk recorded that close observations should be undertaken, it was evident that this arrangement was not wholly effective.

Some people were assessed as at high risk of developing pressure ulcers. We checked the setting of pressure relieving mattresses that were in place to help prevent pressure ulcers developing or deteriorating further and found that not all equipment was correctly set in relation to the person's weight. For example, for one person the setting on their pressure relieving equipment was observed to be set on the highest setting of 135 kilograms and yet their actual weight on 27 March 2016 was 68.40 kilograms and should have been on a lower setting. Another person's pressure mattress setting was observed to be set on 70 kilograms and yet their actual weight on 26 April 2016 was 37.60 kilograms. This meant that the amount of support the person received through their pressure mattress was incorrect and would not aid pressure ulcers from developing or deteriorating further. We made the registered manager and interim clinical care manager aware of our findings on 29 April 2016. However, when we returned to the service on 6 May 2016 and inspected the pressure relieving equipment for both people, we found that the setting remained inaccurate in relation to their weight. We brought this to the attention of the interim clinical care manager. They confirmed that the setting of the equipment had been altered when first highlighted and on the morning of our inspection on 6 May 2016, however they acknowledged that the settings were once again incorrect. Steps were immediately taken to ensure that closer monitoring of these would be undertaken for the future and that staff would be aware of the correct setting.

The service uses an electronic medication management system to ensure staff who administer medication, can easily document medication administration, along with other observations that are logged so to maintain a clear and accurate audit trail.

Medication records were reviewed on both Amazon and Swallow. Observation of medication rounds on both days of inspection showed that these were completed with due regard to people's dignity and personal choice. Although people told us they received their medication as they should and at the times they needed

them, the arrangements for the management of medicines on Amazon and Swallow required improvement. Medicines were not stored safely for the protection of all people who used the service. For example, pain relief gel and eye drops for one person were placed on a table by their chair and were not stored appropriately and safely. The person told us that there were some people who entered their room without their authorisation or consent and touched their personal belongings. This meant that there was a risk that medication could be easily reached for people not authorised to have access. We discussed this with the registered nurse and senior carer on duty and found that neither medication was recorded on the electronic Medication Administration Record [MAR] form and they were not aware that the person was prescribed this medication. The person told us that they were able to self-medicate both medications but at times required support from staff to have their eye drops administered. No assessment had been completed to show that the person had been assessed as competent to administer both medications. This was confirmed by staff as accurate.

We found unexplained gaps on the electronic MAR forms for five out of 11 people, giving no indication of whether people had received their medicines or not, and if not, the reason why it was not recorded Where 'clinical decision' notes were required to provide a rationale for medication omitted, no explanation had been recorded. Medication audits for February 2016 to April 2016 inclusive showed that the latter had been highlighted however steps to remedy this were not effective and staff continued to not complete the records as they should. Additionally, where variable doses of medication were prescribed, the actual dose of medication administered was not always recorded. We also found that one medication for two people was 'out of stock' for a short period of time. This meant that people did not have all of their prescribed medication and systems in place were not as robust as they should be to ensure that medication was ordered in a timely manner. PRN 'as and when required' medication protocols were not evident for all people who were prescribed this medication.

Records relating to the completion of Topical Medicines Application Records were poorly completed. For example, where these should be applied twice or three times daily, it was difficult to determine if staff had failed to administer the topical medication or solely failed to record the administration as these were incomplete.

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

There were varied comments on how safe people felt in the service. Most people we spoke with told us that they did feel safe living at Admiral Court. One person told us, "Yes, I feel safe, and very well looked after." A visiting relative told us, "I believe my relative is safe here, they wouldn't be here otherwise." However, another relative informed, "My relative has had two falls here, and another person hit her too, the service rang and told me each time, and also reported the incident to social services." The relative was happy with the way these situations had been handled, but told us they did not feel totally convinced of their relative's safety at all times. Another person we spoke with told us, "I don't feel safe here. This is not with the staff, but with other residents. It's not the right place for me here and I feel on edge all the time." They added, "A person took my newspaper once and went for me with their stick. I don't want this, I want to relax."

Staff were able to indicate how people may be at risk of harm or abuse and how they would go about protecting them and ensuring their safety. Staff knew about the provider's whistleblowing policy and procedures. Staff told us that they would escalate their concerns to the registered manager. If the concerns were about the registered manager staff stated they would contact the provider and/or other external agencies, such as Social Services.

At our inspection in August 2015 we were concerned about the amount of staff available to meet people's needs. We found that improvements were needed as people were at risk because of inadequate staffing levels. Staff's comments about staffing levels at the service were varied. Although some staff told us that staffing levels were acceptable and they could meet people's day to day needs, others informed us staffing levels were inadequate to meet people's needs and that this could be stressful especially when the home was at full capacity. Staff told us that the impact of this was that people could not always go to bed at the time of their choosing and/or preference. We had concerns about how staff viewed their role and whilst some recognised the importance of interaction, others were task orientated so their views may also be a concern. One member of staff informed us, "There are not always enough staff available. We have less staff than the other team, particularly at the weekend", "It feels like we do not have enough team members to deal with the intensity and unpredictability of our residents. Weekends are particularly bad" and, "Staffing can be difficult at times and there are not always enough staff at the weekend. Staff rotas we reviewed confirmed this. Although this is what we were told, our observations showed that staff deployment throughout the inspection was good.

The registered manager was unable to confirm how staffing levels at the service were calculated so as to determine the number of staff required. The registered manager confirmed that the dependency levels for each person were assessed and recorded each month. However, we found that there was no systematic approach to analyse the results so as to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met people's changing needs and circumstances.

The service ensured that it employed suitable staff because a clear recruitment process was followed. This made sure that staff were suitable to work with people in a care setting. Relevant checks had been carried out including obtaining at least two references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

Requires Improvement

Is the service effective?

Our findings

At the last inspection in August 2015 we noted that most staff had received training to carry out they role. Although staff training records showed and staff told us that they had received suitable training to meet the needs of the people they supported, this was not always embedded in their everyday practice. For example throughout our inspection we observed one member of staff on three separate occasions assisting a person to move in a way that was unsafe and put them at risk of harm. The person was observed to look uncomfortable whilst they were being supported and on one occasion we intervened as we had serious concerns about the well-being of the person being supported. Although records showed that each member of staff had received manual handling training, this showed that staff did not know how to apply their training and provide safe and effective care to the people they supported. Looking through the member of staff's supervision record we found that it had been identified that member of staff in question required addition manual handling training however this had not been arranged or planned. This was raised with the management team who have since commenced an investigation into the allegation and the member of staff have been taken off manual handling tasks until they have been retrained.

Staff informed us that when they commenced employment they went through an induction programme, had ongoing training, one to one support, team meetings and daily handovers. At our last inspection we found several of the staff had not received regular supervision as stated in their supervision agreement signed with the service when staff commenced employment. At this inspection we found supervisions had improved however we found them to be used as a means for the organisation to communicate changes, disciplinary procedures and did not always provide staff with the opportunity to raise individual concerns or issues. Staff informed that there was not enough time in the day for formal supervision to be undertaken. In addition, staff did not see the value of supervision as issues raised in previous supervisions had not been addressed or dealt with. This included issues relating to staff practices, relationships and communication, for example, completion of tasks and responsibilities between staff on different shifts.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at whether the provider had considered the MCA and DoLS in relation to how important decisions were made on behalf of the people using the service. Details on how to involve the person in decision-making according to their individual levels of understanding and preferred communication methods were included in each person's care plan. In addition an Independent Mental Capacity Advocate (IMCA) was available when required to advocate for people, to ensure that people's rights in this area of their care were protected.

The Registered manager had an understanding of the principles and practice of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS]. The registered manager informed us that they worked hard to ensure that people's needs and rights were respected. Appropriate applications had been made to the local authority for DoLS assessments. Where these had been agreed the provider had notified the Care Quality Commission. Staff had received training in MCA and DOLS and understood that they needed to respect people's decisions.

People said they had enough food and drink and were always given choice about what they liked to eat. Throughout both days of our inspection we observed people being offered food and drinks both hot and cold. The service had several jugs of juice placed around the home and these were regularly replenished. All staff were encouraging and supported people to make themselves a drink. People had their specialist dietary needs met, for example, the service were able to cater for people who required a soft food diet. Staff supported people to eat at the person's own pace. We observed a lunchtime meal, which was a very social occasion and people gave positive feedback about the food they had eaten. One person said, "The food here is very good, and we are always given a choice of what we want to have." People's body language showed they were happy with the meal time experience and the food they had been served. The food was cooked using fresh produce, in the morning staff went around to all the people to discuss the meal choices for lunch and tea time.

In general people received effective support to care for their healthcare needs from the GP, District nurse, Dementia nurse and Tissue Viability nurse who visited people requiring support on a regular basis. We found that people received appropriate healthcare support to meet their diverse needs. People and most relatives were happy with the level of healthcare support provided and told us that they were kept informed about people's health and wellbeing.

Good

Is the service caring?

Our findings

At our last inspection in August 2015 we identified that care plans needed to be more person centred and incorporate the views of people and they relatives, in regards to care planning. After the inspection the provider informed in an action plan that all care plans would be reviewed and rewritten by the end of April 2016. We reviewed people's care plans during this inspection and found some that care plans had been reviewed, and detailed each person's preferences of care, including their past life history.

For those people able to verbalise, we were told that staff treated them with dignity and respect. People's privacy was respected and they were able to spend time in their rooms or in communal areas as they preferred. Most people and relatives we spoke to described care staff as 'caring' and 'kind'. One person told us, "They treat me very well. If I need help they'll pop in for a chat, If I want anything they'll get it for me." A visiting relative told us, "I think staff care for her very well, I have no problems with them at all." Another person informed us, "Staff here are absolutely wonderful, I can't fault them." The person went on to say, they had observed staff interaction with other people, and marvelled staff's their patience and understanding. At this inspection and previous inspection it was very difficult to evidence whether or not staff were having meaningful interaction and conversation with people cared for in bed. This was brought to the attention of the lifestyle co-ordinator who in turn implemented an interaction record for everyone living in the service and this would be used as a tool to ensure all staff where spending time with all the people using the service.

Some people were asked for their views and were involved in their day to day care through being offered choice as far as possible in their daily lives. Some relatives we spoke with confirmed that they had been involved in care planning and felt their views were listened to. One relative told us, "The manager and care staff are always around if I have any questions." We spoke to relatives who informed us that the service always sought advocacy support when needed to ensure that people had an independent voice, in addition we found information on advocacy support posted around the home. This meant that people and their relatives had access to the information should they require it. Advocacy services support and enable people to express their views and concerns and may provide independent advice and assistance.

We noted that people were smartly dressed. Staff informed us that people's well-being and dignity was very important to them and ensuring that people were well-presented was an important part of their caring role. People were able to maintain contact and continue to be supported by their friends and relatives. People's relatives told us that they were able to visit the service at any time without restrictions.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in August 2015 we had concerns about person centred care and people's involvement in their care delivery and activities. At this inspection we found that improvements had not been made. The service was unable to evidence how people cared for in bed were being supported to participate in their individual social interests and well-being was not proactively considered or catered for.

Arrangements were in place to assess the needs of people prior to admission. People had plans of care in place and these were being updated at the time of our inspection to a new system. However, we found inconsistencies across the service in the quality of the information included in people's care records. Some provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs. However, others were not fully reflective or accurate of people's care needs. For example, the healthcare professional log for one person identified that they had the medical condition of Cellulitis which meant that an affected area of skin was red, painful and swollen. The care plan relating to skin care and tissue viability provided no information relating to this medical condition and the treatment to be provided. Information was noted to be contradictory and inaccurate as the care plan recorded that the person's skin integrity remained healthy. Not having clear and up to date information regarding the person's condition could affect their care and health.

The records for another person showed that they were at nutritional risk. A formal nutritional screening tool was used to identify those people at risk of malnutrition and showed that between March 2016 and May 2016 they had sustained a weight loss of over four kilograms. This information had not been updated to reflect this within their eating and drinking care plan. Not all care plans or risk assessments had been reviewed to provide the most up-to-date information. For example, one person's eating and drinking care plan detailed that the person was at medium risk of choking however their generic risk assessment relating to the same topic detailed that they were at high risk. We discussed this with two members of staff and neither member of staff was able to confirm which piece of information was accurate. The care plan for the same person detailed that they had several skin tears and pressure ulcers as of January 2016. No updated information had been recorded to confirm that these were healed. This placed the person at risk of not receiving the correct care as staff were not clear about what their needs were and the records were not up to date.

Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Additionally, incidents were recorded for one person who could be anxious and distressed. These showed that between January 2016 and April 2016 there had been 10 incidents. However, no care plan or risk assessment was completed detailing how their behaviours manifested, known triggers and specific guidance for staff on how to deal with incidents to safeguard the person and others. Guidance and directions on the best ways to support the person required reviewing so that staff had the information required to provide appropriate care. Although specific incidents had been recorded where people could become anxious and distressed, little quantitative information was recorded detailing staff's interventions and outcomes.

We found that the needs of people approaching the end of their life and associated records relating to their end of life care needs were not appropriately recorded and improvements were required. For example, the care plan for one person provided little or no information detailing the person's pain management arrangements and the care to be provided so as to provide comfort to the person. No information was recorded to identify who may have a few months, weeks or days to live; in order to aid care planning arrangements and discussions with the person and those acting on their behalf. In addition, no Preferred Priorities for Care [PPC] documents were in use. This is designed to help people prepare for the future and gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of their life.

Although the provider confirmed after the inspection that people and their families were fully involved this was not recorded and care planned for this person which meant we could not be assured that their wishes were being considered and staff did not have the information they needed should they not be familiar with the person's wishes. This was also not recorded in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE] or Gold Standards Framework. The latter places emphasis for a more individualised approach to 'end of life' care. No information explaining what treatment should be provided for their health if they were no longer able to make decisions for themselves was recorded (Advanced Directive). A care plan audit completed on 1 December 2015 recorded that an end of life care plan needed to be completed. At the time of this inspection this remained outstanding. Although the above was noted, multidisciplinary records showed that the involvement of appropriate healthcare professionals, such as the local Palliative Care Team and GP had been undertaken.

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

Information on how to make a complaint was available for people to access. People spoken with knew how to make a complaint and who to complain to. People and their relatives told us that if they had any worries or concerns they would discuss these with the management team, staff on duty or a member of family. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. Although the above was positive, a record was not maintained detailing the specific nature of each complaint, there was not always evidence of the investigation, action taken and proof of how decisions and conclusions had been reached. In addition, the Registered Manager was unable to provide any evidence to show that all complaints received had been dealt with or responded to in line with the provider's complaints procedure. For example, the complaints log provided by the registered manager showed that in January 2016 concerns had been raised in relation to one person not seeing their GP in a timely manner, not having their care needs managed or met and issues with laundry. No other information had been recorded and the registered manager was unable to provide any further evidence detailing the specific nature of the complaint, evidence of the investigation, action taken and proof of how decisions and conclusions had been reached.

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

Requires Improvement

Is the service well-led?

Our findings

There was a lack of managerial oversight and leadership within the service as a whole. During and after the inspection the management team confirmed our findings and informed that additional support had been deployed into home in the form of the Regional Clinical manager who was going to work alongside the management team to help improve the service. Staff did not know what the aims and objectives were for the service. The culture within the service required improvement and there were times when best practice had not promoted or recognised.

The Registered Manager had quality assurance systems place to assess, monitor and improve the quality and safety of the services provided however this had not proved to be effective. They were unable to mitigate the risks relating to the health, safety and welfare of people and others who may be at risk because of the lack of quality monitoring and they failed to maintain accurate, complete and contemporaneous records in respect of each person's care and treatment. Where the provider had completed an internal audit and areas for improvement had been highlighted, the registered manager was unable to provide evidence showing where these had been completed or required to be followed-up. For example, the audits for March 2016 highlighted that care plans for people newly admitted to the service required completion and risk assessments required review. Our evidence at this inspection showed that these remained outstanding and had not been completed.

Prior to the inspection stakeholders including the Local Authority shared with us their concerns which included poor care outcomes for people, medication management issues, a lack of meaningful activities for people and the Registered Manager's lack of response to issues raised to improve care for people which had been raised by the Local Authority earlier in the year. During our inspection we found that the Registered Manager had not addressed the majority of the identified concerns raised by the Local Authority and this was reflective in our evidence of this inspection.

Not all care plans had been reviewed and rewritten in line with the action plan provided by the registered provider following our last inspection. Where care plan audits had been completed, not all actions highlighted had been addressed. For example, the care plan audit for one person showed that a score of 54% had been achieved and several areas for improvement were highlighted, such as, MUST tool not completed each month, dietary advice for the service's chef had not been completed, the dependency profile was out of date, elements of the care plan were noted to be inconsistent and not all elements of the care plan had been consistently evaluated. At this inspection the above had not been completed to show that improvements required had been addressed.

It was apparent from our inspection that although quality monitoring systems were in place for the organisation, the registered manager's failure to action and implement outcomes and concerns from these quality monitoring systems was a contributory factor to the overall service failure and breaches of regulation found during our inspection. The registered manager was unable to demonstrate how they intended to comply with the regulations as set out in the Health and Social Care Act 2008. This showed that there was a lack of managerial awareness and oversight of the service as a whole as to where improvements were

required.

Although some relatives we spoke informed us that they found the service to be well run upon asking, they found the Regional Clinical manager was more approachable, visible and responsive then the Registered manager. One relative said, "From a relative's point of view, I find the management team very approachable." Staff views on who was responsible for the day-to-day management of the service varied. Staff appeared to know who the registered manager was, whilst others told us that there had been a number of changes in the last few months and they were unsure as who they reported to should there be an issue that requires management to resolve these. Some staff told us that communication between staff and the Registered manager was not effective and that support from the Registered Manager was not always consistent with all the staff in the service.

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

Personal records were stored in a locked office when not in use. The registered manager had access to up-to-date guidance and information on the service's computer system which was password protected to help ensure that information was kept safe.

After the inspection we met with the Provider's representatives to discuss our findings from this inspection and also review the services inspection history since the service was registered in 2012. The Regional Manager has given the Commission some reassurances of changes that have already taken place and to mitigate future risk. This being the Regional Clinical manager would continue to support the service alongside the Registered manager in the hope to of drive improvement and they have done so since March 2016. They were confident that they would implement lasting changes to improve the service for people.