Care UK Community Partnerships Limited

Mildenhall Lodge

Inspection report

9 St John's Close
Mildenhall
IP287NX
Tel: 01638445036
Website: www.careuk.com

Date of inspection visit: 17 and 22 December 2014
Date of publication: 28/04/2015

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**

Overall summary

The inspection took place on 17 and 22 December 2014 and was unannounced. The inspection visit on 22 December was undertaken during the evening.

The service was last inspected on 31 July 2014 when it was found to be in breach of a number of regulations which relate to people's care and welfare, quality assurance, record keeping and staffing. We asked the service to take urgent action to improve the care and welfare for people and we checked this at an inspection carried out on 26 September 2014. We found that improvements had been made but we still remained concerned about some aspects of people's care and welfare and so we set a compliance action and asked the provider to send us an action plan outlining how they intended to continue to improve.

At this inspection we checked to see if the service had carried out the required actions to bring about improvements in the service. We found that there was evidence of improvement but that some further improvements were required

The service provides accommodation and nursing care for up to 60 people, some of whom are living with dementia. At the time of our inspection there were 27

Summary of findings

people resident. The service is divided into four almost identical wings. Only three were being used and each unit led on to a communal area with a café and other communal facilities.

The service has had a number of managers since it opened in June 2014 but has not had a registered manager in post since September 2014. 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. The current manager is temporary and will remain in post until a permanent manager is appointed.

We found that staffing levels meant that sometimes people were left without the staff support they needed.

Medicines were managed well for most people but we were concerned that some errors had not been noticed or investigated by staff. We also found that medicines were being given to people later than their prescribed times which could have placed people at risk.

Staff were trained in safeguarding people from abuse. We found that some potentially harmful substances were accessible to people living with dementia. Other risks were assessed and action taken to reduce the risks to the people who used the service. The recruitment process included checks which aimed to make sure that staff could be employed without posing a risk to people.

Staff received the training they needed to carry out their roles and new staff received an induction. Some staff demonstrated an in depth knowledge of the people they were supporting and caring for while others did not.

We saw that staff demonstrated that they understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards DoLS) and acted in accordance with them. The MCA ensures that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People who used the service were very positive about the food and were able to exercise choice about their meals. Special diets were well catered for but we some people did not get the support or prompting they needed to eat their meals. People identified as being at risk of not eating enough were promptly referred to the dietician and monitored. People were also supported to access other healthcare professionals when they needed them.

We found the majority of staff to be caring and committed. People were treated respectfully but people were not always encouraged to be independent or involved in the daily life of the service. People, and their relatives, were unhappy with the lack of things to do and were not supported to follow their own interests and hobbies..

People, or their relatives, were involved in assessing and planning care and had opportunities to meet with staff and review progress.

Formal complaints were managed well but some people found the response to concerns which were raised informally less so

The manager had begun to try to change the culture of the service and had introduced some new initiatives and had improved communication. People were confused due to the large amount of changes in management since the service opened. Most of the people who used the service did not know who the new manager was and had not had formal opportunities to meet with her. Quality assurance systems had not picked up some of the concerns we found on inspection.

We found continued breaches of regulations which relate to record keeping and staffing, as well as a breach of regulation which concerns the management of medicines. You can see what action we have told the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Staffing levels meant that sometimes people were left without the care they needed.

Medicines were managed well for most people but some errors could have placed people at risk and had not been investigated.

Staff were trained in safeguarding people from abuse.

Requires Improvement

Is the service effective?
The service was not always effective.

Staff received the training they needed and were positive about the quality of the training.

Staff understood and implemented the MCA and DoLS appropriately.

People really liked the food and were supported to meet with dieticians and other healthcare professionals if they needed to. Some people did not always get the support they needed to eat their meals

Requires Improvement

Is the service caring?
The service was not always caring.

Staff were caring and treated people with respect.

We observed caring interactions and good relationships between staff and the people they were supporting and caring for.

People were not always encouraged to maintain their independence or contribute to the daily life of the service.

Requires Improvement

Is the service responsive?
The service was not responsive.

People were not supported to follow their own interests and hobbies and told us they were often bored.

People, or their relatives, were involved in assessing and planning their care.

People knew how to make formal and informal complaints. Informal concerns were not always addressed to people's satisfaction.

Requires Improvement

Is the service well-led?
The service was not always well led.

There have been lots of changes of management in a short space of time and people were confused about who was in charge.

Requires Improvement

Summary of findings

There was no registered manager in post.

The new manager was working hard to make improvements to the service but some quality assurance systems were not always effective

Mildenhall Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 22 December 2014 and was unannounced. The visit on 22 December was in the evening.

The inspection team on 17 December consisted of three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of services for older people. The inspection team on 22 December consisted of two inspectors.

Before we carried out our inspection we reviewed the information we held about the service. This included statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with 13 people who used the service, nine relatives, four care staff, two nurses, a clinical development manager, an agency staff member, two members of the housekeeping team, a team leader with responsibility for providing activities and the manager. We also spoke with a chiropodist who was visiting the service.

We reviewed six care plans, ten medication records, four staff recruitment files, staffing rotas and records relating to the maintenance of the service and equipment.

We observed staff providing care and support and 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 communicate with us easily. We carried out a SOFI during a lunchtime service.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 31 July 2014 we found that were not always enough staff on duty to meet people's needs and sometimes people were left without staff support for significant periods of time. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to make improvements. The provider supplied us with an action plan outlining how they would make these improvements. At this inspection we found that an additional member of staff was now routinely on duty but seven people who used the service, four relatives and six members of staff told us that they still felt there were not enough staff to meet people's needs.

One person told us, "I must admit they don't always respond very quickly if I need the toilet. They definitely need more staff". Another person said, "I find that if I ask them to do or get something for me, they're so busy they often forget and don't come back, so I have to ask again when they come back into the room. Enough staff? No way!" Three relatives all commented on staffing being more stretched at weekends. One person said, "[Staff] seem rushed and it's worse at weekends". Although staff told us that staffing levels were better than they had been several of them told us they found it difficult to meet people's needs within the staffing levels.

During our inspection visit on 17 December one person was very anxious about the availability of staff. They told us, "I have sometimes had problems getting attention. Once I [was ill] and I couldn't attract attention". A relative commented, "We are in this lounge with four residents and despite there being three carers on duty, not one has been in for ages. This is typical". We observed during our evening inspection on 22 December that people living with dementia were left for a period of 20 minutes while the two care staff were supporting other people to bed and the team leader was administering medicines on another unit.

Four people living in the two downstairs units needed two people to help them with their mobility and to provide personal care. When two staff were supporting these people and the team leader was administering medicines this left one member of staff for the other 15 people. During our visit on the evening of 22 December the team leader was busy administering medicines for most of the evening. Similarly in the nursing unit the nurse spent most of the time we were there administering medicines leaving one member of care staff to support people. Staff told us that if a second person was needed the nurse would have to stop their medicine round which was described as, "not ideal".

This was a further breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2010).

There were arrangements in place for ordering, booking in, storing and disposing of medicines, including controlled drugs. Staff received training in how to administer medicines and their practice was regularly observed by senior staff to ensure they were competent. We observed medicines being administered to people and saw that staff explained what they were giving to people and obtained their consent. Staff were seen to be very patient and ensured people had taken their medicines correctly before moving on to the next person. Controlled drugs were managed well and stock balances were correct. Stock balances of other drugs were not always accurate which meant we could not be certain that people had received their prescribed medicines as they should. Daily stock audits were not effective as they were not always completed and discrepancies were not always investigated.

We saw that medicines were given later than their prescribed times throughout the day and evening. We noted 12.00 medicines, including those for pain relief which needed at least four hours between doses, being given at 14.30 without a note being added to clarify that the medicine was being given late. The next dose was due to be given at 18.00. During the evening we noted that the medicines round finished at 10.20 pm on two units and at 10.30pm on the other. Some people had already gone to bed and had to be woken up to receive their medicines.

We saw that one person had failed to receive one medicine 18 times in the last 21 days. There was no explanation as to why this medicine had not been given and there was some confusion as to why this person had been prescribed this medicine. We saw that two medicines had not been given to another person on 2 December even though staff had signed to state they had been given. Daily audits had not identified that the medicines remained in the blister pack and staff had not reported it. Medical advice had not been sought about the effect of missing these medicines.

This was a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations (2010).

Requires Improvement

Is the service safe?

People told us they felt safe. One person told us, "I feel safe here and if I was worried I'd find a senior member of staff". This view was echoed by others who felt they could speak to staff if they did not feel safe. Staff received training in keeping people safe from abuse and in how to report abuse if they suspected it had taken place. Staff, including domestic staff, were knowledgeable about the signs and symptoms that someone might display if they were being harmed and knew how to report their concerns to senior staff within the organisation. Staff were not always clear about how to report concerns directly to the local authority safeguarding team but were confident they knew how to raise a concern within the organisation.

Risks to people were assessed, managed and reviewed each month. We saw that people had a variety of risks assessed including those related to falls and maintaining their independence. We noted that one person had had a fall the previous night. The incident report for this person's fall stated that the person had moved to a room with no assistive technology such as a sensor mat to alert staff when someone, who is at risk of falling, was moving about in their room. We found that staff had not been aware that the room did not have assistive technology which put the person at a greater risk and the care plan did not reflect the change of risk.

We found that potentially harmful substances such as hand sanitiser, denture cleaning tablets and topical creams were being stored in empty rooms which were accessible to people. There were also bottles of disinfectant and washing up liquid in the kitchen units. These could put people living with dementia at risk of harm.

Staff employed at the service had been through a thorough recruitment process before they started work. Permanent and agency staff had checks in place from the Disclosure and Barring service to establish if they had any criminal record which would exclude them from working in this setting. All appropriate checks had taken place before staff were employed to work at the service.

Is the service effective?

Our findings

People who used the service told us that they were reasonably happy with the way staff supported and cared for them but three people who used the service and five relatives told us that they felt new staff and agency staff were not familiar with people's needs before they worked unsupervised. One person said, "There's definitely a problem with new staff. They just don't seem to know anything about you". Another person echoed this saying, "The agency and newer staff are nowhere near as good and don't seem aware of the systems at all". A relative also commented that, "I have been asked, 'What are the routines?'". We observed some confusion around which meals people had chosen because new staff were not familiar with people's needs. Although people, and their relatives, expressed some reservations about the skills and experience of the staff we found that overall people acknowledged that things had begun to improve.

We saw that staff received the training the needed to carry out their roles and new staff received an induction. Staff were positive about their induction. They told us that they had spent time shadowing permanent members of staff before they worked unsupervised. Staff also received supervision and an appraisal system was in operation. We found that there was a mixed picture with regard to supervision. Some people received regular support and guidance while others had not had supervision for several months. Three new staff were not clear when their probationary period would be completed.

Staff were positive about the quality of the training and commented that there were opportunities to increase their knowledge in areas such as wound care or dementia for example. A lot of training was face to face and staff were positive about the interactive nature of much of the training sessions.

The manager and care staff demonstrated an understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). We saw that in most cases people's consent was asked for before care and treatment was provided and if people did not have the capacity to consent for themselves we saw that the appropriate professionals and relatives or legal representatives had been involved to ensure that decisions were taken in people's best interests. We saw that some decisions had been appropriately taken in people's best interests and appropriate DoLS applications had been submitted to the local authority. We found that one person had received a flu vaccination without the appropriate best interests process being followed.

People were very positive about the food and the kitchen staff in general. One person told us, "Mealtimes are something to look forward to". Another person said, "The food is tasty and very good all round. The kitchen staff deserve praise for all they do". We observed mealtimes on all the units and saw overall they were relaxed and enjoyable .People were able to have their meals where they wanted and times were flexible. We saw that where people needed to have their food pureed to make it easier to swallow, each different item was pureed individually and presented attractively to tempt people, who may be at risk of not eating enough, to eat their meal. Food was served hot but those people who needed help to eat sometimes had to wait a long time for help and we could see their meals were no longer hot.

Some people, who chose to eat in their rooms, did not receive the prompting and supervision they required and so did not always finish their meals or have a drink. We observed one person struggle to cut up some chicken for 10 minutes and then just push it around their plate. This was then removed by staff and no alternative was offered. Snack plates and high calorie smoothies were brought round to encourage people who were at risk of not eating enough and we saw that some people were prompted and encouraged to eat them while others did not receive any staff support and the plates were taken away untouched. We observed one person failing to eat their snack plate as they had spilled their drink on it. This was not noticed by staff despite two staff checking on the person. The food and the rest of the drink (which had gone cold) were removed and no alternative offered. Light foods and snacks were available for people in the evening on each of the units.

People's weights were monitored and where it was noted that someone had lost weight they were promptly referred to the dietician for advice and guidance. We saw that food and fluid charts for those people at risk of not eating or drinking enough, were completed and people were promptly referred to the GP if they failed to meet their fluid targets. We noted that people's weights were generally stable and some people on the nursing unit had recently increased their weight due to added attention to their diet.

Requires Improvement

Is the service effective?

Records showed that people had access to a variety of healthcare services including GPs, opticians, dentists and chiropodist. One person said, “I see a dentist. The chiropodist comes. I have only needed to see a doctor one but it’s all sorted out”. The chiropodist was visiting the service when we inspected and told us that they felt that although people were promptly referred to them for treatment, sometimes people’s feet were not washed or dried properly which could lead to skin problems.

We saw that staff were not always following one person’s diabetic care plan which stated that should their blood glucose level be higher than 8.5 two hours after meals the test should be repeated. We saw that readings considerably higher than this had been recorded on seven occasions in the last two weeks but the reading had not been repeated. Although the time of each test was recorded it was not recorded if the person had the test before or after a meal. Staff had recently liaised with the GP over this person’s diabetes and their medicines had been changed but their care plan remained unclear.

Requires Improvement

Is the service caring?

Our findings

We found that some people who used the service were positive about the way the staff provided care and support while others had reservations. One person told us, “There are some of the staff you can have a real laugh with which makes the day that much brighter for me”. Another person told us, “I am quite happy and well looked after”. Other people said that staff were caring but felt that sometimes they were so busy they did not have time to chat. One person commented, “Though the staff do their job, they just don’t have time for a laugh or a joke. They are just too busy”. Another said, “Some are friendly and seem to really care but some seem to just do the job”.

Relatives also presented a mixed picture with some praising the kindness and compassion of staff while others felt that staff did not have enough time to spend with people or found them ‘task driven’. There was an acknowledgement from some relatives that things were improving. One relative commented, “Some staff are good fun, while others just come in, plonk the tea down an walk out - but I think it is improving overall”.

We observed staff treating people with kindness and compassion. We saw that staff demonstrated patience whilst supporting people who were living with dementia and saw that caring relationships had developed between some of the staff and those people they were supporting and caring for. We observed staff on the nursing unit supporting people to eat their meals and saw that they worked at the pace of the person they were supporting and chatted to them as they helped them eat their meal.

People were able to tell us about how staff respect their choices. Several people told us how they were able to decide when they went to bed and where and when they ate their meals. One relative told us, “[My relative] gets a choice of bedtimes. [They] go to bed late and get up late”.

Not all staff were able to tell us about people’s life histories which was a concern where they were caring for people living with dementia. Although there was some detailed information in people’s care plans about how to support them we found that some plans only included limited information about how to support people to manage their anxiety. We saw that the care plan for one person, who was distressed and seemed anxious, contained inadequate guidance for staff about how to manage this. Newer and less experienced members of staff were not aware of how to support the person and reduce their distress. We also found that records did not document what type and stage of dementia this person had and staff were not aware of how this might impact on the person’s behaviour.

The team leader responsible for activities told us that, as part of their aim to involve people in the running of their home and increase their independence, they encouraged people to help out with tasks such as folding laundry and making their own sandwiches. We did not see, during either of our visits, people being involved in this way and this did not match what people who used the service told us. None of the people we spoke with told us that they contributed to the running of the service by helping out with any daily task. One person told us that they would like this opportunity and said, “I’d have a go at anything!”

We did observe people being encouraged to eat their meal independently on the nursing unit and staff took a prompting role and assisted them only when needed. This maintained people’s independence and enhanced their self esteem.

We observed people receiving care and support which maintained their dignity. People were asked discretely if they wished for support with their personal care and this was offered privately. However we did see that one person who was trying to get out of bed with their nightclothes not covering them and protecting their dignity. The bedroom door was open and this person could be seen by anybody going past their door.

Is the service responsive?

Our findings

People who used the service, or their relatives, had been involved in developing their care plans. One relative told us, “Our family is involved in [my relative’s] care plan and we tell them if something isn’t right. If so we’d have a meeting. When and if needed”.

The service operated a ‘Resident of the Day’ programme and staff would meet with the person and, if appropriate, their relatives to discuss any issues and review their care each month. The manager told us that in addition to this programme there were also regular meetings held with the people who used the service. We saw a notice advertising a meeting for 16 December but the manager told us that this meeting had not taken place.

Care plans contained information about how people would like to receive their care and support and identified particular information staff needed to know before providing care. We found that the records were difficult for staff to negotiate and sometimes important information was not able to be produced quickly which meant that although the information was logged staff may not be aware of it. Care plans were regularly reviewed and promptly updated in most cases when there was a change of need identified. Care plans did not document who people were happy to receive personal care from. One person told us they would prefer to receive care from a female member of staff but this was not recorded and they told us that this did not always happen.

The main issue people wanted to talk to us about was how they spent their day. Most people, many relatives and some members of staff told us that there was nothing for people to do and that they were unable to follow their former interests and hobbies. One person told us,” The TV is on so that’s it really. It just stays on and we just sit there all day”. Another person commented, “It’s more or less TV all the time. There’s hardly anything else”. A third person said, “There’s just nothing to do. Ok so we might get people coming in and singing or whatever but it’s few and far between”. Nearly all the people we spoke with described the television as their main entertainment and this was what we observed. It was also clear to us that people were not routinely asked if they wanted the television on and if they did what station. One person told us, “The TV channel is on when we come in the lounge and it gets stuck on the channel. We just sit here all day and watch whatever it is that is on”.

On the day of our inspection we saw that the team leader with responsibility for activities was making Christmas crackers with people. We saw that three people were supported by two staff to make crackers whilst other people did not receive any input from staff and were mainly left to watch television. We also noted in the dementia unit that the television was on in the lounge and the radio was on in the dining area. The radio was playing pop music and one person commented on the noise but staff did not turn it down or offer to change the channel. We saw no evidence that people enjoyed listening to the music or were actively watching the television.

The activities co-ordinator told us about some recent entertainment the service had organised and people told us that they had really enjoyed this. They also said that providing things for people to do on the nursing unit was ‘a struggle’ but said they were hoping to organise a sensory box for people. There were no interactive displays for people to experience and we noted that a lot of the pictures were at a level too high for people using wheelchairs to appreciate. The manager told us that additional training was being provided for staff to teach them about ‘activity based care’ but we did not see that this had impacted on the service yet. We saw that work had taken place to fill the small cabinets outside each room with personal items and photos of the person and their family which personalised the entrance to each room. We noted that the activities co-ordinator also had a care role and on the day of our inspection we could see that sometimes this was a priority. Whilst there was more of a commitment to providing things for people than at our last inspection, the overwhelming message from people was that they were bored.

People told us they had not been asked what they would like to do with their day or how they would like to spend their time. One person said, “I’ve not been asked for my views on any aspect of the home. There’s definitely a lack of entertainment or activities”. Some relatives felt the service could do more to encourage people to form relationships with each other. One relative said, “This home needs to encourage people to get to know each other. Sometimes

Requires Improvement

Is the service responsive?

it's as if they are in their own little bubble". Two members of staff also commented on the need for more community involvement both within the service and in the wider community.

The service had a complaints procedure and people, and their relatives were aware of it and some had made formal complaints in the past and told us they had been responded to appropriately. We found that there was a mixed picture about how the service responded to informal issues raised by people who use the service or their relatives. Some people told us that staff responded quickly to deal with concerns. One relative said. "Staff listen to concerns anyway. They are all very helpful- they always respond to any requests or need for attention". Three relatives were less happy about the way staff responded to their concerns. One person was concerned about a particular aspect of their relative's health and told us they had raised this a number of times with staff but, "They don't seem to make any effort".

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 31 July 2014 we found that there was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010. This was because care records at the service were both electronic and paper and sometimes these records conflicted with each other which could have place people at risk. We also found at that inspection that some staff were not confident in using the electronic system and records were not able to be located promptly. At this inspection we found that considerable improvements to records had been made but some issues still remained.

The electronic records themselves were very detailed and daily notes were written up several times a day. Having such a lot of detailed information recorded sometimes made it difficult to pick out specific pieces of information which might be needed to ensure people's needs were being met.

Several members of staff told us that there were problems with the electronic system, including the inability to log in sometimes, insufficient training in its use and a lack of time to write care notes up which meant that notes were often written up at the end of a 12 hour shift and not throughout the course of the day as they are supposed to be. We also found some information could not be produced. We asked to see some daily bowel movement charts for one person and there was confusion about where this information was being recorded and when they clarified this the records for the last two weeks could not be found and had still not been located some hours later. This could have placed the person, who was unable to tell staff about their pain, at risk as they may have needed medicines or a medical appointment due to an issue to do with their bowel movements but staff might have been unaware. Where notes were available these were recorded in two different places. Additional examples of this kind of confusion were found on all the other units.

This was a further breach of Regulation 20 of the Health and Social Care Act 2008 Regulated Activities (2010).

At the inspection carried out on 31 July 2014 we found that there had been a breach of Regulation 10 of the Health and Social Care Act 2008 Regulated Activities (2010). This was because systems to monitor the quality of the service were not effective and did not protect people. At this inspection we found that this area had improved significantly. In the week (although not at weekends) daily meetings were held with team leaders to enable the manager to pass on important information and to have an overview about what was going on in each unit. The meeting also offered staff the opportunity to find out what was going on in other units, although we found that team leaders left as soon as they had fed back about their unit. We observed that these meetings took staff away from their direct caring roles. Staff told us that they found these meetings were helpful and that communication had improved greatly since the current manager came into post.

The registered manager had left the service shortly before our last inspection.. There have been several changes in management at the service since that time and the manager in place at the time of this inspection had been in post for a few weeks and was intending to stay until a permanent manager was appointed who would then apply to be registered with the Care Quality Commission. The manager was supported by two deputy managers, one of whom was a permanent member of the staff team. Other Care UK staff were also offering management support to the service on a part time basis. Staff commented about the instability of the management team but there was an acknowledgement that things were definitely improving. Most staff told us that previously they had not felt supported by the organisation or the manager but said this was also improving. Some staff felt less supported and were confused about who was responsible for what, given that there had been so many changes. One staff member commented that the new manager ensured that people were accountable for their actions and was trying to encourage team work.

An audit system was in place to assess and monitor the quality of the service provided. Audits and spot checks were carried out regularly by the manager and senior staff. We also saw that the provider regularly updated the service's improvement plan and the manager's line manager was visiting the service on the day of our inspection. The manager told us about planned improvements they hoped to make to systems and to equipment in each of the units. The manager had an overview of the staff's training needs and told us they were in the process of arranging some safeguarding training for staff whose training was out of date. We noted that some of

Is the service well-led?

the issues which we found during the inspection process, including medication errors, confusing and incomplete records and staffing concerns, had not been picked up and addressed by the audits which the service carried out

People who used the service were unclear about the management of the service and very few of them knew who the manager was. Comments such as, “There’s been so many changes here, I have no idea who’s in charge”, and, “I don’t know who’s in charge. There seem to be lots of people who aren’t nurses” were typical of the views people expressed. One person said, “I reckon I know everything that goes on in this place but I have no idea who’s in charge!” We observed the manager in different areas of the building but did not see much interaction with the people who used the service. We also saw little evidence of the commitment to ‘activity based care’ which the provider states is at the heart of the service.

Although meetings with people who used the service and their relatives took place, people told us they felt there were few opportunities for them to influence or comment on the running of the service. People met with the care staff to review their care but one person who used the service and three relatives told us that if issues were raised they were not always followed up. One relative said, “We have been asked for our views by Care UK but frankly nothing happens".

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use the service were not protected against the risks associated with the unsafe use and management of medicines because the provider did not have appropriate arrangements for the recording, dispensing and safe administration of medicines. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use the service were not protected against the risks of unsafe or inappropriate care because an accurate record in respect of each service user was not maintained and could not be located promptly when required. Regulation 20 (1) (a) and (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The health, safety and welfare of people who use the service were not safeguarded because the provider did not ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff. Regulation 22.