The Hollies Nursing And Residential Home Limited

Hollies Nursing and Residential Home Limited

Inspection report

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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

A comprehensive inspection was carried out at Hollies Nursing and Residential Home on 11,12 and 14 June 2018. The first day of the inspection was unannounced.

Hollies Nursing and Residential Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home is a large detached property and accommodates up to 39 older people on two floors. At the time of the inspection there were 30 people accommodated in the home.

According to CQC records, there was a registered manager in place who was also one of the owners of 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. However, during our conversations with this person, they advised us they were not aware that they were registered as manager as they had thought this registration had lapsed when the manager in post at the time of the previous inspection had successfully registered with CQC in 2015. This manager had subsequently left the home in January 2018 when a new home manager had been appointed; this new manager was in post at time of this inspection and was responsible for the day to day running of the home. However, following the inspection they advised us they had tendered their resignation to the providers. The registered manager advised us they would therefore be undertaking the responsibilities of the role with immediate effect.

At the previous inspection in January 2018 we identified three breaches of regulations; these were in relation to the management of medicines, recruitment procedures and systems to monitor the quality and safety of the service. We issued a warning notice in relation to the management of medicines. We also asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective and well-led to at least good. This inspection was undertaken to check whether the required improvements had been made.

During this inspection, we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; this was because care plans were not always person-centred. We also identified continuing breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems for the safe handling of medicines needed to be further improved and the systems in place to monitor the quality and safety of the service were not effective. We are considering what action we will take in relation to this breach. Full information about the CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

This is the second consecutive time the service has been rated as 'Requires improvement'.

Although audits were in place in relation to care plans and medicines, these had not been effective in identifying the shortfalls we found during this inspection. Although the provider took immediate action to rectify some of these shortfalls prior to the end of the inspection, it should not have been necessary for CQC to bring these matters to their attention.

Care plans were not always sufficiently personalised or detailed enough regarding people's diverse needs. We observed an occasion during which care staff did not follow the care plan when assisting a person to mobilise. This meant there was a risk the person might come to harm.

Medicines were not stored at the correct temperature and records relating to the administration of topical creams and eye drops needed to be improved.

The call bell system did not operate safely in some rooms. This meant there might be occasions when care staff would not be able to hear and respond to the emergency buzzer. This was rectified before the end of the inspection. Staff told us this had previously been brought to the provider's attention but no action had been taken.

Our review of records showed there had been a number of incidents of aggression from one person who lived in the home. However, when questioned the manager was unaware of these incidents and had therefore not taken the appropriate action to safeguard people who lived in the home and staff. Following the inspection, we received confirmation that the required safeguarding referrals had been made to the local authority and relevant notifications submitted to CQC.

There were limited opportunities for people who lived in the home to provide feedback on the care they received. People were unaware of their care plans and told us they had not been involved in any reviews of how their care needs were met. We were told a 'resident of the day' system had recently been introduced but this was not yet embedded in care planning systems. Although most people we spoke with told us they were happy with their care, one person told us staff did not have a good understanding of their particular needs. It was clear from our conversations with this person, that they had not been involved in discussions about their care with the manager or staff.

People told us they felt safe in the home and that staff were kind, caring and respectful towards them. With the exception of one incident, this was confirmed by our observations during the inspection.

Staff had been safely recruited and there were enough staff on duty to meet people's needs. The manager told us there were ongoing difficulties with the recruitment of permanent qualified nurses but regular agency nurses where used wherever possible. Two new nurses had recently been recruited to work in the home.

With the exception of fire safety training, all staff had received training relevant to their role. New staff received an induction when they started work at the home. However, no care staff had received any formal individual supervisions since the last inspection. The manager told us they had only had the time to provide supervision to nursing staff. This meant care staff did not have the opportunity to discuss and record any training and development needs they might have.

The provider was not working within the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. Although DoLS applications had been submitted to the local authority for people who were unable to consent to their care arrangements in the home, one person's care records did not detail the significant restrictions which were in place within the

home to protect them and others. This was rectified before the end of the inspection.

People enjoyed a varied diet and changes in their health were monitored and acted on. However, we noted one person did not have a care plan in place regarding a health condition. This matter was rectified before the end of the inspection and the person told us they did not have any concerns about the care they received.

Although the design and layout of the home was generally suited to the needs of most people who lived in the home, we noted no consideration had been given to any adaptations which might need to be made for a person who had a visual impairment. Our observations during the inspection showed all areas of the home were clean and significant improvements had been made to infection prevention measures.

During the inspection, we did not see any evidence of activities taking place. We were told this was because the activities coordinator was on sick leave. People spoken with during the inspection told us they were generally happy with the range of activities usually provided.

Staff told us they enjoyed working in The Hollies and that the manager had introduced changes which had improved the way the home was run.

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 is not consistently safe.

Although improvements had been made to the way medicines were handled, we identified concerns that medicines were being stored at temperatures which meant their effectiveness might be compromised.

Staff had been safely recruited and there were enough staff on duty to meet people's needs. Staff were aware of the correct action to take should they witness or suspect abuse.

Staff did not always act in accordance with the information contained in people's care records. This meant there was a risk people might come to harm.

We identified concerns in relation to the way the call bell system functioned, although this matter was addressed by the provider before the end of the inspection.

Is the service effective?

Requires Improvement

The service is not consistently effective.

The manager had made improvements to the training provided to staff. However, care staff did not receive individual supervision.

Care records did not always contain information about the restrictions in place to help ensure individuals received the care they needed.

People told us the quality of food was good. Where necessary, people's nutritional intake was monitored.

Although people's health needs were assessed, one person's care records did not document the support they required in relation to a health condition.

Is the service caring?

Good

The service is caring.

People told us staff were kind, caring and respectful towards them.

With one exception, we noted positive interactions between staff and people who lived in the home.

Staff respected people's rights to privacy and dignity.

Is the service responsive?

Requires Improvement

The service is not consistently responsive.

People's individual needs were not always recorded or appropriately met.

Most people were happy with the way their care needs were met. However, we saw no evidence that people were involved in developing or reviewing their care plans.

We saw no evidence of activities taking place during the inspection. The manager told us this was because the activities coordinator was not in work due to sick leave. People spoken with were generally happy with the activities provided.

Is the service well-led?

Requires Improvement

The service is not consistently well-led.

The registered manager had failed to carry out the responsibilities of their role.

The systems in place to monitor the quality and safety of the service were not effective.

Staff told us they enjoyed working in the home and considered the manager had made improvements to the way the home was run.

Hollies Nursing and Residential Home Limited

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 11,12 and 14 June 2018; the first day of the inspection was unannounced. The inspection team on 11 June 2018 comprised of one adult social care inspector, an assistant inspector and a specialist nurse advisor. One adult social care inspector and an assistant inspector carried out the second day of the inspection. One adult social care inspector returned on 14 June 2018 to undertake the final day of the inspection.

In preparation for our visit, we contacted Healthwatch, the local authority contracting unit and the infection prevention team for feedback and checked the information we held about the service and the provider. This included statutory notifications sent to us by the service about incidents and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

When planning the inspection, we used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with eight people who lived in the home and three relatives. In addition, we spoke with the manager, a registered nurse, three members of care staff, an agency staff member and the cook.

We observed how care and support was provided to some people who were not able to communicate their

views to us. To do this, 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.

We had a tour of the premises and looked at a range of documents and written records including a detailed examination of six people's care and medication records, five staff personnel files and staff training records. We also looked at a sample of policies and procedures, complaints records, accident and incident documentation, meeting minutes and records relating to the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in January 2018, this key question was rated as 'Requires improvement'. At this inspection, the rating remains 'Requires improvement'.

We identified concerns regarding the safe handling of medicines at our last inspection in January 2018 and took enforcement action regarding this matter. Since this inspection, the manager had made a number of improvements. However, several areas needed further action.

There was a missing signature two of the six medicines administration record (MAR) charts we reviewed; these related to eye drops which each person had been prescribed to receive at night. The manager told us these gaps related to when an agency nurse had been on duty. We also found some medicines had not been dated when opened; this is important as some medicines need to be disposed of after a certain number of days once opened as they may otherwise lose their effectiveness.

Records had not been fully completed to show when staff had administered prescribed topical creams. Two people's cream charts did not contain any administration instructions for staff to follow. In addition, the cream charts for a further four people contained a number of missing signatures. This meant we could not be certain from looking at the records, whether the creams had been administered as prescribed. In addition, the manager told us they were aware that cream charts were not in place for people who required nursing care.

Following our findings at the last inspection, the manager had taken the decision to change the way prescribed medicines were stored. This meant medicines had been moved from a room which was inappropriate to use for their storage, to individual cabinets in people's bedrooms. However, we found that no consideration had been given to the temperatures at which medicines were now being stored. As a result, when we checked three people's bedrooms on the first day of the inspection, we noted that medicines were being stored above the required temperature which meant their effectiveness might be compromised. We were told this situation was replicated across the rest of the home. By the final day of the inspection, action had been taken to remove all medicines to a central storage area. In addition, the provider had made arrangements for an air conditioning unit to be installed in the room to ensure the temperature was properly controlled. We were told an urgent business development meeting was to be arranged to agree a more permanent and appropriate solution to the storage arrangements for medicines.

The issues with the storage of medicines and the administration records relating to prescribed topical creams and eye drops was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there was a medication policy in place, this lacked detail and did not include any reference to best practice guidance. A policy was in place to guide staff about the action to take if an individual refused to take their prescribed medicines and it was decided that it was in the person's best interest for their medicines to be administered covertly, i.e. in food or drink without their knowledge. We checked the records

for one person whose medicines were administered covertly and found the appropriate procedure had been followed.

All staff responsible for the handling of medicines had received training for this task. The manager had assessed the competence of three of the six staff responsible for the administration of medicines.

Medicine administration record (MAR) charts contained photographs of people living in the home to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduced the chance of someone receiving a medicine they were allergic to. Documentation was available to support staff to give people their medicines according to their preferences.

At our last inspection, we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; this was because recruitment processes were not sufficiently robust. During this inspection, we found all required pre-employment checks had been made before people started work in the home; these included references and checks with the Disclosure and Barring Service. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. In addition, procedures were in place to ensure nurses employed in the home were appropriately registered with the Nursing and Midwifery Council (NMC).

During our last inspection, we received mixed feedback about staffing levels in the home. We made a recommendation that the provider made use of a recognised tool to determine how many staff were required on each shift. At this inspection, we saw that people's level of dependency was regularly assessed. All the people we spoke with during the inspection told us there were usually sufficient numbers of staff on duty to meet their care needs, although we noted the provider often had to rely on agency nurses due to difficulties in recruiting qualified staff. We were told this situation was due to improve as two nurses had recently been employed to work in the home.

People who lived in the home told us they felt safe and well cared for. Comments people made included, "We feel safe because everyone looks after us" and "I feel very safe here." However, when we asked one person if they felt safe they told us, "Yes too safe". When we asked why they had responded in this way they told us, "Because we can't move; we want to spread our wings. We have restrictions because we can't just go out; we need help." They told us they did not feel there were enough staff on duty to be able to meet their specific needs. The relatives we spoke with had no concerns about the care of their family members.

At our last inspection, we noted poor practice in relation to health and safety and infection control. As a result, we made a referral to the local authority infection prevention team and, following their visit, an action plan was completed by the manager. During this inspection, we saw that improvements had been made and no concerns were identified.

The provider had systems in place to assess, manage and review risks, including those relating to mobility, falls and nutrition. However, on the first day of the inspection we observed one member of staff supported a person to transfer from their wheelchair to a dining room chair; this was not in accordance with the risk management plan in the person's records which stated two staff were required to help the person transfer safely. We were unable to speak with this individual but spoke with another person to ask whether the right numbers of staff always supported them to mobilise. They told us, "No and I need two staff. It's very hit and miss it can be one or it can be two." We also noted a staff member pushed a person in their wheelchair without any footplates in place. These findings meant there was a risk people might come to harm.

When we looked at one person's care records, we noted there had been five incidents which had occurred

during April and May 2018 during which the person had been aggressive towards other people who lived in the home and staff. When we discussed these with the manager, they told us they were unaware of the incidents as the information had not been handed over to them by staff. This meant they had not updated the person's care records or considered whether safeguarding alerts needed to be raised with the local authority to help protect people who lived and worked in the home. Following the inspection, the manager sent us the required notifications regarding relevant incidents. The person's care records were also updated to give clear guidance to staff about how they should best support the person should they display behaviour which challenged others.

The failure to report and take action in relation to incidents in which a person's behaviour challenged others was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted there was a system in the home for staff to report any required repairs or maintenance issues. The provider employed a maintenance person to work across the three homes they owned. One of the directors was also responsible for overseeing the maintenance of The Hollies.

During the inspection, we were informed by the manager and staff about problems with the call bell system. We were told a fault in the system meant that, should the person in a particular bedroom use their call bell, the emergency buzzer system used by staff to request assistance would not sound and staff needed to visually check for a flashing light to alert them to any emergency. Although we were initially told this only related to one bedroom, staff told us that a number of rooms on the old call bell system were affected and that this was a known and long-standing problem which had previously been reported and brought to the attention of the providers but no action had been taken. When we discussed this with the director responsible for maintenance in the home, they told us they were unaware of the specific fault we referred to. We asked them to immediately check the system to ensure people would be safe in the event of an emergency. They arranged for the company responsible for maintaining the call bell system to visit the home and, following tests, the fault was identified and rectified. The director told us, as a result of our findings, the decision had been made to bring forward work on the call bell system and that all bedrooms would be transferred over to the new system by 22 June 2018.
Records we reviewed showed regular checks took place of the environment and the equipment used by staff. However, when we checked water temperatures, we found the water from one bath tap was 75 degrees, significantly above the safe limit of 43 degrees. We saw that this bathroom had most recently been checked on 15th May 2018 when the water temperature was found to be within safe limits. When we brought this to the attention of the provider, they took immediate action to prevent people from accessing the bathroom and repaired the defective valve before the end of the inspection.

We saw that the business continuity plan had been updated since the last inspection. This document now contained key contact details and information for staff to follow in the event of an emergency. There was also an emergency 'grab bag' in place, which included the information about how people should be safely evacuated from the building, the fire plan for the home and items including torches and foil blankets which staff could use to help people remain safe.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2018, this key question was rated as 'Requires improvement'. At this inspection, the rating remains 'Requires improvement'.

At the last inspection, we found some staff had not received required training updates. During this inspection we found that, with the exception of fire safety, all staff had received required training including refresher training as needed. The manager told us they would arrange for the in-house training provider to deliver a session on fire safety as soon as possible.

Staff confirmed that, since the new manager had started work at the home, training had improved significantly and was provided to a high standard.

Effective processes were in place for the induction of new staff. All new staff were expected to complete a detailed induction programme, supported by a mentor from within the staff team. The allocated mentor signed to say the new member of staff understood their responsibilities and had completed tasks to the required standard.

Although staff spoken with told us they received regular supervision, the training matrix completed by the manager showed only registered nurses had received formal supervision. The manager told us, they had been concentrating on providing group supervision to care staff, particularly when any issues of concern had been identified. They told us they recognised the importance of offering staff the opportunity to discuss their training and development needs on an individual basis and intended to introduce this as soon as possible.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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. Records we reviewed showed the manager had submitted DoLS applications for 10 people who were unable to consent to their care arrangements in the home; two of these applications had been assessed and authorised by the relevant local authority.

People's needs were assessed before they were admitted to the home. The pre-admission assessment was then used to formulate a set of draft care plans to meet each individual's identified needs. We noted some of these care plans needed to be further personalised to ensure they reflected people's choices and

preferences.

We looked at one person's care records who was subject to restrictions in the home, to help protect other people and ensure the individual received the care necessary to meet their needs. We noted there was no care plan in place to explain the purpose of any restrictions and how staff should support the person within the home in the least restrictive way possible. On the final day of the inspection, we were shown that the person's care plans had been completely rewritten to better reflect the way staff should support them and protect their rights, particularly their right to a private and family life in the home.

Staff told us that, wherever possible, they supported people to make decisions about how they wished their care to be provided. This was confirmed by our conversations with people who lived in the home. They told us staff always respected their rights and preferences. Comments people made to us included, "Staff know how we like things to be done" and "We can do whatever we want here."

People told us the quality of food was good in the home; this was confirmed by our observations during the inspection. We saw people had two choices for each meal and alternatives were offered if a person did not like what was on the menu. Appropriate arrangements were in place to monitor the nutritional and dietary intake of people assessed as being at risk in this area. Where necessary, referrals had been made to specialist services including the speech and language therapy team (SALT).

People's health needs were assessed and plans put in place to ensure these needs were met. There was a registered nurse on duty 24 hours a day to meet the needs of people who required nursing care.

We noted one person did not have a care plan in relation to their diabetes; this was rectified before the end of the inspection and the person told us they had no concerns about the care they received. Relatives of another person told us they had been told their family would receive physiotherapy in the home to assist them to reach their goal of returning home. However, this was not reflected in the person's care records. We discussed this with the manager who told us they would request input from the physiotherapy team.

The design, decoration and layout of the home was suited to the needs of most people who lived there. Each person had a single bedroom and we were told people were encouraged to decorate their rooms with their own possessions to help create a homely environment. With the exception of one person, people told us they were happy with their bedroom. One person told us they felt staff could have a better understanding of their needs in relation to the environment due to their visual impairment.

Good

Is the service caring?

Our findings

At our last inspection in January 2018, this key question was rated as 'Good'. At this inspection, the rating remains 'Good'.

People spoken with during the inspection told us the staff in the home were kind, caring and respectful towards them. Comments people made to us included, "The staff are very nice", "They are very good here at looking after us. They treat us very well" and "Staff are very respectful when helping me in the morning."

On our arrival at the home on the first day of the inspection, we heard staff raising their voices in relation to a person who had opened the door to us; this was because they were concerned about them leaving the home and placing themselves at risk. All other interactions we observed were positive. Staff were seen to laugh and joke with people and spend time discussing people's plans for the day.

People's privacy and dignity was respected. We looked at a sample of care records and found staff wrote about people's needs and care in a respectful manner. Each person had a single room and people told us they could spend time alone if they wished. We observed staff knocking on doors and waiting to enter during the inspection. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting.

Staff told us they would always encourage people who lived in the home to be as independent as possible. One staff member told us they tried hard not to do things for people which they were able to do for themselves.

We were told people had the opportunity to comment on the care they received during daily conversations with staff. A 'resident of the day' system had recently been introduced, although this was not yet embedded in care planning systems.

People who lived in the home and their relatives were provided with information about the service in the form of a service user guide. This information would help people to decide whether the home was suitable for their needs or the needs of their relative. We were told this information could be provided in different formats if required.

The manager was aware of contact details for the local advocacy service. People can use advocacy services when they do not have friends or relatives to support them or want help from someone other than staff, friends or family members to understand their rights and express their views.

People's right to confidentiality was protected. There was a confidentiality policy in place which documented staff responsibilities and the importance of protecting people's personal information.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in January 2018, this key question was rated as 'Good'. At this inspection, the rating has deteriorated to 'Requires improvement'.

We looked at the care records for six people and noted each person had a set of care plans which were supported by a series of risk assessments.

With the exception of one person, people spoken with during the inspection had no concerns about how their care needs were met. Comments people made to us included, "If you need any help, they [staff] will do it", "If you want to go somewhere, they [staff] will assist you." However, no one could recall discussing their care needs with the staff. We also saw no evidence in the care plans looked at that people had been involved in the development and review of their care plan. This is meant people had limited opportunities to have control and influence over their care provision. We were told a 'resident of the day' system had recently been introduced, although this was not yet embedded in care planning systems.

During the inspection, we spoke with one person who told us they did not consider staff had a good understanding of their specific needs and therefore did not always provide them with the support they required. When we looked at the person's care records, we found these did not provide detailed information about the person's visual impairment. In addition, no attempts had been made by the provider to contact local services which might be able to offer advice, support or information to improve the person's experience in the home. Following our initial enquiries with relevant local organisations, we passed their contact details on to the manager who agreed to follow this up after gaining the agreement of the individual concerned.

There was a lack of person-centred care planning to ensure staff responded appropriately to people's diverse needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we discussed with the manager the requirements of the Accessible Information Standard (AIS); this standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The manager told us they were unaware of this standard but would check the requirements of the AIS to ensure they were compliant with them.

During this inspection, we found the provider had not introduced any policies or procedures in relation to the AIS. However, we saw that people's communication needs were documented on their care records as well as the action staff should take to ensure people were supported to communicate their needs, wishes and preferences.

The manager informed us there was an activities coordinator employed to work in the home, although they

were not in work due to sickness on any of the days of our inspection. We were told the activities provided included outside entertainers, a local choir and a theatre company as well as in-house activities for small groups and individuals. However, we did not see any planned activities taking place during the inspection and one person told us, "We don't do much here." One person told us they had a machine to play audio books in their room but they were unable to use it and did not like to ask staff for support to do so. When we discussed this with the manager, they told us they were unaware of this. We also did not find any evidence that the person had been provided with individual support to meet their specific social needs or had the opportunity to discuss their support needs with staff.

There was a system in place to investigate and respond to complaints. We noted two complaints had been received since the last inspection in January 2018. The complaints log only contained details of the issues raised in one complaint as the second was being investigated by the local authority safeguarding team. We advised the manager that the log should be updated to ensure a complete record was maintained of any concerns raised, the actions taken to resolve these and any lessons learned.

We saw that the service was using a range of technology to improve the care and support people received. The manager told us the home utilised an online assessment system called 'Telemedicine' if they had any concerns about people's health. This service was available 24 hours a day and was managed by registered nurses from the local NHS service. 'Telemedicine' provides a remote clinical service between the home and a healthcare provider, using electronic audio and visual means. This helped to ensure people had access to prompt and appropriate advice and treatment. In addition, equipment such as sensor mats and door sensors helped to ensure staff were able to respond promptly and provide people with the support they required.

The manager told us there was no one in receipt of end of life care at the time of this inspection. However, when necessary, the provider worked in partnership with specialist services such as Macmillan nurses to help ensure people receiving end of life care had access to appropriate equipment and pain relief medicines.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in January 2018, this key question was rated as 'Requires improvement'. At this inspection, the rating remains 'Requires improvement'.

According to CQC records, there was a registered manager in place who was also one of the owners of the service. However, during our conversations with this person, they advised us they were not aware that they were registered as manager as they had thought this registration had lapsed when the manager in post at the time of the previous inspection had successfully registered with CQC in 2015. This manager had subsequently left the home in January 2018 when a new home manager had been appointed; this new manager was in post at time of this inspection and was responsible for the day to day running of the home. However, following the inspection they advised us they had tendered their resignation to the providers. The registered manager advised us they would therefore be undertaking the responsibilities of the role with immediate effect.

Our findings during this inspection showed systems in place to monitor the quality and safety of the service were not effective.

Care plan audits were in place to identify any gaps in recording people's needs or whether monthly reviews had taken place. Records we reviewed showed any actions required to address the issues identified had not been followed up. For example, we looked at a care plan that had been reviewed by a nurse in February 2018 but no further action had been taken since that date. When we queried this with the manager, we were advised this was because the home was understaffed and did not have enough permanent nurses to complete follow up actions required. The home had struggled to retain nurses since the last inspection. However, we were informed that the recruitment of new nurses, the manager was hopeful that this would change. The manager also told us they were in the middle of implementing new review procedures and new care plans that should make the process easier and more robust.

Care plans at the home needed to be more person centred and the audits completed had not been sufficiently robust to identify this shortfall. We reviewed the care records of a person who was registered blind and noted the care plans did not provide much detail around this, nor was it detailed enough to provide staff with the knowledge required to help them carry out their role with this individual. This person's care plan also showed that staff had not undertaken any specialist training or support to help ensure they were able to provide this individual with safe and effective care. We also found an example where people's relationships needs were not identified or guidance provided to staff about how they should be supported. The care plans we reviewed had been completely re written and were more person centred by the time inspection was complete. We were assured that every care plan would be amended in this way. However, the audits in place should have been robust enough to notice the shortfalls we identified.

The storage of medicines had recently altered at the home. However, we found that the decision-making process behind the change was flawed and the potential risks involved had not been considered. We noticed that medicines were being stored in rooms where temperatures were not being checked. Room

temperatures were reaching over 25 degrees on the days of our inspection and the rooms housed medicines that needed to be stored below this temperature; this could potentially reduce the effectiveness of the medicines. Before the inspection was completed medicines were moved back to a single room where temperature was being monitored and an air conditioning unit was installed. Although the provider took immediate action to mitigate risks, they should have identified these risks without the need for intervention by CQC.

Medicines audits were in place which showed any shortfalls were identified and actioned. There were systems in place for staff to complete daily and weekly checks to help reduce the risk of medicines not being administered as prescribed. However, our review of records showed these were not always completed, particularly when agency nurses were on duty. We also noted that the checks for the week prior to the inspection had not been completed. The manager told us they were responsible for auditing whether these checks had been properly completed and were aware of the gaps we had identified. However, they told us they considered it was difficult to address them with agency staff.

During the inspection, we identified a number of concerns relating to the recording of when prescribed topical creams had been administered. We also noted that some topical creams and some eye drops had been opened without staff recording the date when they had done so. This meant, it would have been difficult for staff to know how long medication had been open for; some medicines need to be disposed of 28 days after opening as otherwise their effectiveness may be reduced. We discussed our findings with the manager who told us the administration of topical creams was not included in the current audits completed. They informed us the audit would be amended to ensure it included checks on the storage of medicines and whether required cream charts were in place and fully completed.

The provider had a range of policies and procedures in place. However, when we reviewed a sample of these policies, we noted at least three referred to out of date legislation. Policies were signed as read by the manager but we saw no evidence to confirm that staff had read and understood the policies. During our last inspection, we noted the need for an Accessible Information policy and we found that on this inspection no progress had been made in this area. With the exception of the safeguarding policy, the staff handbook included key policies and procedures but again staff had not signed to say they had read this important document.

We looked at the systems in place to enable people who lived in the home, their relatives and staff to provide feedback to the manager or provider. Records we reviewed showed limited amount of staff supervisions had taken place since January. This meant some staff did not have the opportunity to reflect on their practice or receive feedback on their performance.

Since our last inspection no service user surveys or residents' meetings had taken place. The manager told us that these were planned to take place in the future.

We were concerned that minutes from a managers' meeting promoted sharing of passwords between staff for the internal computer. We raised this with the manager due to the fact that such practice is not in line with current data protection regulations.

During the inspection, we asked the manager for any trend reporting for accidents or injuries or lessons learned. From the information provided to us, we noted there was no robust system in place to monitor this.

From the records we reviewed, we noted there had been a number of incidents of aggressive behaviour from

one person who lived in the home. However, the lack of robust audits and poor communication between staff and the manager meant the necessary safeguarding referrals had not been made to the relevant local authority. This meant there was a risk that people were not properly protected. Following the inspection, we received the required notifications which confirmed the local authority safeguarding team had been made aware of the incidents.

Regular quality monitoring visits had been carried out by the provider's representative. Although these visits were recorded, it was not obvious from the records what shortfalls had been identified and whether all required actions had been completed by the manager.

There was a lack of robust processes to monitor the quality and safety of the service. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008

During the inspection, we found the manager to be transparent and honest about our findings. When we discussed with them the required improvements in the home, they told us to date they felt that they had been reactive to issues. However, they also said they believed they were getting to a point with the home where a more proactive approach could be taken.

Our observations during the inspection, showed the manager had taken the necessary action to improve infection control measures in place in the home, They told us they were proud of the improvements they had made in this area.

Records we reviewed showed that relatives' meetings and staff meetings happened regularly. Staff told us they were able to raise any issues of concern in staff meetings and felt their views were listened to.

People who use the service spoke positively about the manager. Comments people made to us included, "She comes round every day and talks to me" and "The manager is very nice. She comes and sees us every day to check everything is alright." In addition, staff said of the manager, "Things are a lot better since the new manager has been here. Staffing levels have improved and things are getting done around the house", "The manager sets high standards but we know if we have any problems we can approach her. She doesn't try to be our friend but she's there for us" and "[Name of manager] is firm but fair." The consensus from staff was that the manager was approachable and proactive in making improvements within the home.

During our inspection our checks confirmed that the provider was meeting the requirement to display their most recent CQC rating both in the home and on the provider's website. This was to inform people of the outcome of our last inspection.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of person-centred care planning.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The systems in place to ensure the safe handling of medicines needed to be improved.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality and safety of the service were not effective.

The enforcement action we took:

We issued a warning notice