Abbeville RCH Limited

Abbeville Sands

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 16 and 18 May 2016 and was unannounced. Abbeville Sands provides accommodation and care for up to 20 older people, some of whom may be living with dementia. At the time of our inspection there were 16 people living in the home.

A registered manager was in post. 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, the registered manager wasn't managing the service on a day to day basis. A new manager had been managing the home since February 2016. They were yet to apply for registration as the service manager. We have referred to this person as the manager throughout this report.

Prior to this May 2016 inspection the service had been inspected in August 2015. The August 2015 inspection had found breaches of three regulations. The breaches related to poor identification and management of risks to people's welfare, people's medicines not being managed safely, poor cleanliness of equipment and people's bedding, ineffective governance of the service and unsafe recruitment processes. Our May 2016 inspection found that whilst improvements had been made in the cleanliness of the service, the same concerns remained as had been identified at our previous inspection.

The provider and registered manager had a poor oversight of the service and had not ensured that improvements had been implemented and sustained since the August 2015 inspection.

There was little understanding of how to manage risks to people's welfare with the use of standard risk assessment tools. As a result people could not be sure that risks to their wellbeing in relation to pressure areas, falls and their nutritional requirements would be identified and reviewed on a regular basis. This meant that there was potential for staff not to be aware when people's health was changing and their support requirements needed updating.

We found some improvements in management of people's medicines. However, some areas such as the recording of creams administration and protocols for medicines prescribed for people on a 'when required' basis still required further work. We also found other concerns including the crushing of medicines without seeking the advice of a pharmacist who would be able to say if the medicines were safe to be crushed. This put people at risk of receiving medicines that were unsafe or ineffective.

Whilst people's health concerns had been identified upon admission to the home, care plans were not always in place to provide staff with information about the type and manner of support people required with specific health issues that impacted upon their daily lives.

There were enough staff deployed to meet people's needs. However, proof of identity for staff had not been

obtained. Recruitment checks were not robust enough to mitigate the risks of employing staff unsuitable for their role.

Staff training had expired and steps had only been taken to remedy this after we had inspected another of the provider's services and found similar concerns. This put people at risk of receiving care from staff that was inappropriate or unsafe.

People enjoyed the food but improvements were required to ensure that staff supported and encouraged people to eat and drink enough.

People and their relatives were mostly positive about the support they or their family member received from staff and we observed good practice during our inspection.

Staff were positive about the new manager's appointment and were supportive of each other. The majority of people and their relatives felt that the manager would ensure any concerns or queries they had would be dealt with effectively and to their satisfaction.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider had not made significant improvements to reduce the risks to people's welfare that were found during our August 2015 inspection.

Risks to people's health had not always been reviewed. People's medicines were not managed safely.

The recruitment process was not robust to ensure the risks of employing unsuitable staff were minimised.

Staff knew how to minimise the risks to people of abuse and enough staff were available to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Most staff training had expired.

People's ability to make their own decisions had not been consistently determined.

Improvements were needed to ensure that people were supported and encouraged to eat and drink enough.

People had access to health professionals to maintain their wellbeing and act upon any concerns, but external appointments required better organising.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff had a kind and caring approach with people and ensured they were treated with dignity, but some people had reservations about the caring nature of some night staff members.

People and/or their relatives were involved in discussions about how people's needs were planned and met.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual preferences had been determined but there was little information to guide staff how to support people with specific health conditions.

People were confident to raise concerns or queries with the manager and felt that they would be responded to.

Is the service well-led?

Inadequate

The service was not well led.

The provider and the registered manager had a poor oversight of the quality of the service and had not made improvements in this area since the last inspection.

The provider had failed to ensure that improvements were made since the August 2015 inspection as many of the same issues remained.

The manager had the support of the staff in the home who worked well together as a team but required better support and guidance from the provider and the registered manager.

Abbeville Sands

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 16 and 18 May 2016 and was unannounced. The inspection team comprised of two inspectors.

Prior to this inspection we reviewed information we held about the service. We reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During the inspection we spoke with seven people living in the home and relatives of five people. We made general observations of the care and support people received at the service throughout the day. We also spoke with the manager, registered manager, five care staff, the cook and a visiting community nurse. We reviewed four people's care records and medicines administration record (MAR) charts. We viewed three records relating to staff recruitment as well as training, induction and supervision records.

We also reviewed a range of management documentation monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Our last inspection in August 2015 had identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because risks to people's welfare were not always identified or mitigated, people's medicines were not being managed safely and some bedding and equipment was unclean.

At this inspection we found risks to people's welfare that were similar to those identified during our August 2015 inspection. The provider had not taken action to improve risk assessments to help ensure people's safety and welfare. Whilst there had been some improvements in the management of people's medicines, concerns remained in this area.

Three people had been assessed as being at risk or high risk of developing pressure areas. However, whilst pressure relieving equipment was in place the risk assessments had not been reviewed since they were completed in November or December 2015. There was no guidance in place for staff to advise them of the actions required to reduce the risks to people. One person, who had moved in to the service three months ago did not have a risk assessment in place for pressure areas, despite them having restricted mobility. We checked the bedding for one person identified as at high risk of developing pressure areas and found that their base sheet was wrinkled and not fitted properly to the bed. Wrinkled bed sheets can lead to friction on the skin which can contribute to the development of pressure areas.

People were being weighed regularly. However, nutritional screening assessments were not always carried out at the same time. One person, who was already at a weight that placed them at risk of malnutrition, when last weighed in April 2016, had lost four kg in a three week period. A plan to support the person with their nutrition dated April 2016 said that weekly weights were required. These were not being carried out. The person had been prescribed food supplements, but records showed that only about half the amount of what had been prescribed was received by the person. The person's food and fluid intake was being recorded. However, minimal records of fluid intake were made and no quantities were shown. The person was awaiting a visit from the dietician. However, the concerns presented a risk to the person's welfare and this concern was referred to the local authority's safeguarding team.

The service operated a falls risk assessment process whereby assessments needed to be re-assessed whenever a person experienced a fall. This did not take into account that changes in a person's general health, mobility or medicines could in the meantime increase their risk of a fall. One person's falls assessment had been completed in February 2015. The person had experienced three falls since then but their falls risk assessment had not been reviewed. One person, who had moved in to the service three months ago, did not have a falls risk assessment in place, despite them having restricted mobility.

Our August 2015 inspection found that risks associated with the legionella bacteria, which can be found in water, had not been assessed since May 2013 to ensure that adequate measures were in place to control the risks. Associated routine water systems checks were also not being carried out. This inspection found that no action had been taken to address this issue.

The August 2015 inspection found issues regarding the management of people's medicines. We had found discrepancies between medication administration records and quantities of medicines available to give to people. There were gaps in records of medicine administration, including creams required for external application. Prescribed creams had not been safely stored and refrigerator temperatures were sometimes too low. There had been no written guidance for staff about how and when they could administer medicines prescribed for people on a when required basis.

This May 2016 inspection found that there were still areas of concern. We looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines. We found gaps in records of medicine administration including medicines prescribed for external use. Therefore records did not confirm that people were receiving these medicines as prescribed. For one person prescribed two types of food supplement to help them nutritionally there were a significant number of gaps in records of their administration with the risk the person was not receiving the food supplements as prescribed.

We looked at supporting information available alongside medication administration record charts to assist staff when administering medicines to individual people. When people were prescribed medicines on a when required basis, there was sometimes written information available to show staff how and when to administer these medicines. One person living at the service told us they often needed painkilling medicines which were prescribed in this way and that they received them promptly when they advised staff they were in pain. However, we noted that there was still not always written guidance in place when medicines were prescribed in this way. The manager confirmed to us that there were approximately 20 such medicines still without guidance. Therefore people may not have had these medicines administered consistently and when appropriate.

For one person, there was a complex schedule of high-risk medicines prescribed where the administration of one medicine depended on a daily blood test and a daily telephone call from the clinic to the home. We noted that records about the telephone calls and instructions were not clear placing the person at risk of receiving the wrong dose of the medicine.

Another person was having their medicines administered to them crushed and placed in food to enable them to swallow them. Crushing medicines can adversely change the way they are absorbed into the body placing people at risk of receiving their medicines unsafely, however, there were no records confirming that the service had checked to ensure their medicines could safely be administered in this way.

These findings meant that the provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Medicines were stored safely for the protection of people who used the service and at correct temperatures. There were now appropriate arrangements in place for the storage of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Our last inspection in August 2015 had identified a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because safe recruitment procedures were not in place to ensure the risks of recruiting unsuitable staff were minimised.

Two of the three recruitment records did not contain photographs or proof of identity for the staff member which is required by legislation. One staff record only contained one reference which covered an 8 month employment period only. Details for previous employers were contained in the application form, but the

provider had not sought references to cover a lengthier timescale which would have provided a more satisfactory history of conduct or capability. A second staff record showed that a reference had not been obtained from the person's last employer in the care sector for whom the staff member had worked for 16 months. The person had not worked in the care sector prior to this previous employer. However, a reference had been obtained from another employer. The person had been allowed to commence duties in the home without the service having received a reference from the person's last and most relevant employer.

These findings meant that the provider was still in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Sixteen people were living in the home at the time of our inspection. The manager advised that they had recently begun to use a dependency tool to help calculate a safe level of staffing. They told us that three staff members, including a senior carer, were on duty during the day and two care staff were on duty overnight. A cleaner worked six days a week, a cook worked 8am until 2 pm and an activities staff member worked two days a week for three hours at a time.

The majority of people felt that there was enough staff to support them when they needed assistance. One person told us, "There is generally enough staff, but they're pushed sometimes." Another person told us, "They're quick to answer call bells." A third person said, "Staff always come when you buzz." However, one person told us that they had to wait for up to 30 minutes for their call bell to be answered.

Staff told us that there were enough staff on duty at any one time and that they could meet people's needs. One staff member said that that tea times could be hectic as a staff member had to prepare food for people, which left two care staff members 'on the floor' in the run up to teatime. However, this depended on who was doing the kitchen work as they felt that some staff were more capable in this area than others.

Relatives told us that there were enough staff available but one felt that staff needed to be more visible in the lounges to keep an eye on people. They told us that they had sat in one of the lounges for up to two hours on occasions without staff checking in to see if people were okay.

Staff members we spoke with understood their responsibility to ensure people were protected against abuse. They described the types of abuse people could be exposed to and knew what signs to look out for and the actions they would need to take if they had any concerns.

People told us that they felt safe. One person told us, "I'm very safe in here." One relative said, "My family member tells me that they feel so much safer here than when they were in hospital." Another relative told us that they could relax as they knew that their family member was safe and cared for in the home and staff would act promptly in any emergency. A third relative told us that the service looked after some money for their family member and it was all "..double signed in and signed out. It's done properly and I can check it any time."

Our last inspection in August 2015 identified that people's bedding and some equipment in the home was not clean. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This May 2016 inspection found no concerns in this area. Consequently, the provider was no longer in breach of Regulation 12 in so far as it related to infection prevention and control.

Requires Improvement

Is the service effective?

Our findings

Staff had not received sufficient training and support to carry out their roles and responsibilities. Some staff, including new staff members, had received training for moving and handling which had been completed in May 2016. In common with the provider's two other services that had been recently inspected, the remaining staff training had expired. Classroom based training for infection control and mental capacity had been arranged, but this had only been done after shortfalls in training were identified during our recent inspection of the first of the provider's other two services. The manager had retained copies of training new staff members had done with previous employers so they had some assurance of their knowledge. The provider's ongoing training programme was mainly done through online training, with practical sessions on moving and handling for care staff and first aid for senior care staff. Most shifts were operating without a staff member on duty having a current first aid certificate.

A staff member who was managing the provider's home care agency had been organising training. They had become too busy with managing their service to be able to continue to do this, so staff training had fallen behind. However, new arrangements had not been made in a timely manner.

These failings meant that people were at risk of being supported by staff that did not have adequate or up to date training.

These findings constituted a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the home felt that staff were competent. One person told us, "Staff here are well trained and well skilled." Another person said, "The staff know what they're doing."

Staff we spoke with who administered medicines told us that they had up to date training for this. The manager, who had been in post since April 2016, told us that they had completed competency testing for most staff who administered medicines. We saw records confirming both medicines administration training and medicines competency testing. We also found that the manager was making good progress with staff supervisions given the short time they had been in post.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

Staff had a basic knowledge about supporting people to make their own decisions when necessary. They told us they sought people's consent when offering them support and respected their wishes if they declined. One staff member said, "I always offer people choices and respect their decisions. I know I can't force people to do things against their will." Another staff member told us that they used different approaches to see what people responded best to. For example, they told us how they would ask a question in a different way or wait a while to see if the person would change their mind.

The provider had followed the requirements of the DoLS and applications to the local authority had been made in respect of some individuals whose freedoms had been restricted in order to help keep them safe. Care records in respect of mental capacity were variable. Some were good and gave clear information to staff on what sort of decisions people could make and what decisions they would require support with. However, records for some people living with cognitive impairments did not include information about their ability to make their own decisions.

People were positive about the food and most told us that they always received choices. One person said, "I don't get everything I'd like to eat, but the cook did some liver for me and I really enjoyed it." Another person told us, "The food is good here, I've no complaints." A third person said, "I can't remember what I had for lunch but I remember enjoying it!" We saw that people had options for meals and that the cook tried to accommodate people's preferences where possible. For example, one person's records showed that they liked toast with egg and tomatoes for breakfast and we saw them enjoying this one morning.

The cook told us that they tended to cook from scratch rather than rely on pre-cooked food wherever possible. They told us how they catered for people on special diets, for example those requiring a diabetic diet. They were knowledgeable about what foods people liked and those they didn't.

During this inspection we observed one lunch time period in the main lounge. Staff came in to bring people their people their meals, but did not check in otherwise. One person kept falling asleep and then when they awoke they took a considerable time cutting up their food up so that they could eat it. By the time they started eating it, it would have been cold. Staff told us that the person was very independent and didn't accept staff assistance to cut up food. However, had there been staff available to encourage them when the food arrived it would have been hot when they ate it. Another person in this lounge, who was at considerable risk of not eating enough, may also have benefited from staff encouragement. They ate very little and slept periodically through lunch.

People had drinks when their meals commenced, but these ran out during lunchtime and were not refilled. There were two jugs of squash in the room, but people in the lounge were not able to get themselves a drink without assistance. The squash was kept by the window and was in direct sunlight and would have been warm. Two relatives felt that their family members were not always provided with enough drinks. They told us that sometimes they were not changed frequently enough and on occasions when they visited the drinks had run out.

The service was recording food and fluids for all people living in the home, irrespective of whether they were at risk of not eating or drinking enough. However, no quantities of fluid were recorded and there was no indication of what the optimal amount was that people needed to drink in order to avoid dehydration. Consequently fluid recording was not effective. Improvements were needed to ensure that people were supported and encouraged to eat and drink enough.

People told us that they had good access to see health professionals when necessary. For example, people were supported by GPs, visiting community nurses and dentists. One relative told us that staff identified

when their family member's behaviour had changed, that they were unwell and took prompt action. Another relative told us how staff had sorted out problems their family member was having with their hearing aid.

However, two relatives expressed concerns that routine appointments were not effectively organised and planned for. On one occasion transport had not been organised in time for one person to attend a planned appointment. On another occasion staff had taken one person to an appointment to find that there was no appointment booked for them.

Requires Improvement

Is the service caring?

Our findings

Most of the people we spoke with told us that staff were caring. One person said, "Staff are always pleasant." A relative told us, "Staff are friendly and kind and my [family member] gets on well with them." Two people living in the home felt that some staff were more caring than others. One person gave an example where a staff member had been heard being rude to someone living in the home and being disrespectful when talking about other people. Some people had reservations about some night staff and felt that they were not very supportive. One person said, "The night staff aren't always about." A relative told us how they had found their family member in tears after a night staff member had refused to let them go back to bed after they had supported them to go to the bathroom in the early hours. However, they added that this had been promptly and satisfactorily dealt with by service managers.

The televisions were on in both lounges all day, but people showed little interest in the programmes that were on. One person told us, "It's just noise. Horrible." The programmes were modern daytime TV programmes. We were unable to determine whether these programmes were chosen by people living in the home. Two relatives told us they thought their family members would have preferred to listen to music sometimes or watch a dvd of something that might be of more interest to them.

People told us that they chose where they wanted to spend their time in the home and where they wished to have lunch. One relative of a person who chose to spend their time in their room told us, "Staff do ask [family member] if they want to go downstairs for a change, but they prefer to stay in their room these days." Another relative told us that they were pleased that staff encouraged their family member to have their lunch in the dining room sometimes, rather than the lounge. They felt their family member benefited from the stimulation provided by a change in environment.

We observed that staff supported people in a caring manner. One person had told a staff member that they wished to go to the bathroom. The person needed staff support to rise from their chair and transfer to a wheelchair using their walking frame. The person was a little anxious about this. The staff member spoke gently and clearly in a confident tone and talked the person through each stage of the process, saying what they were going to do or what they needed the person to do. The person responded well to the staff member's calm manner which instilled confidence in them. Once the person had transferred to the wheelchair they had relaxed and were smiling.

One person who didn't eat much lunch was asked gently by a staff member why this was. They replied that they had pains in their hands. The staff member crouched down so that they were at the same level as the person and gave the person time to explain exactly how they were feeling before they suggested how to alleviate their discomfort.

People told us that they were supported to be as independent as possible. One person said, "They encourage me to do what I can, like washing my top half." Another person said, "Staff ask if I want help with something, they don't assume that I do." A relative told us that staff were patient. They said that their family member tended to use their call bell a lot, but that staff were not flustered or irritated by this.

Staff respected people's privacy. One person told us that staff always knocked and waited for their response before entering their room. They said "It's very dignified here at all times." Another person said, "They get me settled on the commode, but will go and wait for me to buzz before they return." A staff member told us that if two people needed to provide care to someone then as soon as the task is completed and the remaining support can be provided by one carer then the second staff member leaves.

Most people told us that they were involved in their care to the extent that they wanted to be. One person said "They ask me what I want to happen, how I'd like things done." Relatives said the home communicated with them well and told us that their participation was welcomed in their family member's care. One relative told us, "I am involved in [person's name] care, anything that happens I know that staff will call me immediately."

The manager had commenced meetings with people living the home to seek their views. We saw that they had taken the time to go to people's preferred locations and speak with them there. Their first meeting had taken place over two lounges and a discussion had been held with one person in their room.

Requires Improvement

Is the service responsive?

Our findings

The information about people's assessed needs relating to health conditions they were living with and how staff could support them appropriately was poor and not person-centred. The care plans of two people showed that they were visually impaired. However, there were no care plans to detail the extent of their impairment and what actions staff needed to take to help support them and ensure their safety and welfare in this regard. There were no care plans to show how people living with diabetes were to be supported. Two people required reliever sprays to be with them at all times in case of an asthma or angina attack. However no care plans were in place to provide guidance for staff to identify symptoms of an attack so that staff could support people to prevent the attack from happening.

One person had health conditions which meant that they required their legs to be elevated as much as possible and periods of bed rest as advised by the community nurse. We also saw on the second day of our inspection that they used pressure relieving equipment to avoid pressure damage to their heels. There was no care plan to show what actions staff needed to take or how frequently they needed to take them to support this person in accordance with the nurse's directions. These issues put people at risk of receiving inappropriate care.

Substantial sections of the care plan for one person who had moved into the home three months ago had not been completed. These included moving and handling, falls and pressure area risk assessments, dietary care plan, and an overnight preferences and needs assessment. Another person's care plan had not been reviewed since November 2015.

Our August 2015 inspection identified that little provision had been made to support people to pursue hobbies or interests. This inspection found that few improvements had been made in this area. Some people chose to stay in their rooms and others spent time in the lounge areas, mainly sleeping. A few people had regular visitors who took them out. A staff member was employed to support people socially for six hours a week. People told us that activities provision had just re-started at the home and that the staff member responsible had been asking people what they would like to do. We observed two people enjoying a lively game of jenga and that the dining room had been decorated with a 'tea-room' theme. However, there was little time to support people to any meaningful extent with their individual hobbies or interests. One person told us, "I've been told that staff will take me out for a walk if I pay £7 per hour."

The concerns constituted a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Most people's care records contained person centred information about their likes and dislikes. For example, we saw indications of what people liked to eat and their night-time preferences. One person said that they liked their door open and a side table lamp on overnight and they told us that this was routinely done.

One person had their dog living with them. Practical arrangements and written agreements were in place to

ensure that this didn't adversely affect other people living in the home. The person told us, "I'm so happy to have my dog here. It means everything to me."

People told us that they had choices in most things, but two people said that they were assisted with baths or showers according to a schedule. However, they did not mind this. One person said, "It's practical I guess." Another person told us, "I get choices about what to have for tea and where I want to have my meals."

Most people told us that they would feel confident in raising any concerns or complaints with the manager. One person said, "I'm listened to, but I'm not sure that anything would be done." However, other people and their relatives were positive. One person told us, "I've no need to complain here." Another person said, "I can talk to the manager here, but I've no complaints." A relative said, "If you query something the manager will soon get it sorted for you." Another relative said, "I would trust [the manager] with any concerns."

Inadequate

Is the service well-led?

Our findings

There were two registered managers for this service. One was no longer working for the provider as a manager, but had not applied to deregister. The other registered manager was also the registered manager of another of the provider's three services. They spent the majority of their time at the other service. There was a new manager in post at this service, but they had not registered with us, but told us that they intended to do so. The registered manager explained that they were managing their own service, overseeing this service and a third service operated by the provider because the managers were new in post. They were also leading the implementation of a computerised care records system across all three homes. They advised us that they would be de-registering as the manager of this service once the manager had registered.

The manager told us that they had worked for the provider for three years and had taken up the manager's role at this service three months ago. However, they had not been able to devote all of their time to managing the service until the beginning of April 2016 as they had been needed to lead shifts at both this home and another of the provider's services.

Our last inspection in August 2015 had identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because systems were not in place to monitor the quality of the service effectively to prevent the risk of people experiencing poor care.

Audits were in place for health and safety, fire safety and infection control and were up to date. However, a medicines audit had not been completed since March 2016. The content of some audits required improvements to ensure that all risks were covered. For example, the health and safety audit did not consider the management of risks to people and staff relating to electrical, gas or lifting equipment servicing or risks associated with the outside areas to which people had access.

There was no care plan auditing system in place. The registered manager had been unclear on how care plan content was determined and what level of detail they would expect or their expectations about how risks to people's welfare were identified or mitigated. Consequently, the new manager was not aware of what was expected of them in relation to care planning. People and their relatives could not be assured that the service was identifying or meeting people's needs.

The provider did not conduct any audits to determine the quality and safety of the service that people received. This had been identified as a concern in our August 2015 inspection, but no action had been taken to rectify this. The manager said they had not received any formal supervision from the provider, but said that they had frequent contact and felt supported by them.

The manager told us that they had no job description, but had had discussions with the registered manager and the provider about what the role entailed. They were on a three month probationary period. They had received one supervision from the registered manager. However, this was scant in detail, only recording a discussion about staff sickness management. The manager told us that they could rely on support from the registered manager whose own service was in the next street. They were currently completing their level 3

Diploma in Health and Social Care and told us that they would be able to commence their level 5 Diploma Health and Social Care leadership when funding became available.

The provider did not understand the importance of ensuring that risks to people's welfare were identified and reviewed and had no systems in place to do so. They had not identified the poor practices in place in the service.

The provider had not determined whether there were systemic failures in the way that their services operated and were managed. Their leadership had not ensured that suitable and effective systems were in place to manage the service in order that people's needs were met and to drive necessary and outstanding improvements that were required forward.

These findings meant that the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person told us, "The home isn't badly run. [The manager] is alright. Another person said, "The manager is very pleasant, but I don't see much of them." Staff were positive about the manager and how the home was run. "There's good teamwork here. If I found something that was wrong I'd have no problem flagging it up to the manager." Another staff member told us, "The manager is beginning to make positive changes here." One staff member said, "The owner rarely comes in. When they do sometimes they'll get fish and chips arranged for tea which is nice because people enjoy that. But they're not approachable and they don't acknowledge people."

Staff told us that they were well supported by the manager and staff worked together well as a team and felt valued. One staff member gave us an example of a suggestion they had made to the manager that had been taken up. They said that staff meetings were held and the manager often attended shift handover meetings so they were aware of what was going on and so were able to respond to issues that were raised and organise things that needed to be done to ensure shifts ran as smoothly as possible and people received the care that they needed in a timely manner.