Finecare Homes (Stevenage) Limited

Roebuck Nursing Home

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

This inspection was carried out on 2 August 2016 and was unannounced. At their last inspection on 18 and 23 April 2015 the service was found to not be meeting all the standards we inspected. This was in relation to infection control practices and security of records. We also found that staffing, restraint processes and management systems required improvement. They sent us an action plan setting out how they would make the necessary improvements. At this inspection we found that they had made sufficient improvements in relation to infection control and the security of records. However in other areas, they were not meeting all the standards. This was in relation to management of medicines, staffing, the Mental Capacity Act and Deprivation of liberty, the consistency of records about people's needs and management systems.

Roebuck Nursing Home provides accommodation, care and nursing for up to 63 people, some of whom live with Dementia. At this inspection 50 people were living at the service.

The service has a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

We found that people received a good standard of care and the feedback about the staff and registered manager was positive. However, we found that the systems and processes in place were ineffective and inconsistent. This related to audits, checks and other governance systems.

People told us that staff were kind and caring. People also told us that they felt involved with the planning of their care. We found that care plans about people's needs were incomplete in some areas, however, staff knew people's needs well.

People and their relatives gave mixed views on staffing levels at the home. However, we saw that staffing had been raised as an issue at the last inspection and via an independent survey. We found this remained an issue, in particular on the top floor where people were living with dementia. Staffing numbers impacted on people's mealtime experiences and the provision of activities.

People told us they felt safe and staff were aware of how to keep people safe. However, noted that medicines were not always managed safely and the system for reviewing accidents and incidents needed improvement.

Recruitment files needed reviewing to ensure that all appropriate pre-employment checks were carried out prior to staff members starting work. We saw that staff received sufficient training for their role.

People did not always have their mental capacity assessed or have best interest meetings about their needs. Although the registered manager had applied for DoLS to help ensure people were not unlawfully

restrained, we saw that staff used a form of restraint to keep people safe and there was no guidance available about the least restrictive options to be used.

People felt the registered manager was approachable and would address concerns and complaints they raised. Staff were clear of their role and respected the registered manager for their firm approach to help ensure people received good care.

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

Requires Improvement

The service was not always safe.

People's medicines were not managed safely.

There were insufficient staff deployed to meet all people's needs.

Recruitment files needed improvement to ensure all checks were completed prior to staff starting work.

People felt safe living at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always assessed in accordance with MCA and DoLS.

People were asked for their consent before care was delivered.

People had enough to eat and drink. However, the mealtime experience and nutritional assessments needed improving.

People had access to professionals when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity.

People and their relatives felt involved in their care.

Confidentiality was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were incomplete.

Activities were provided for groups of people living on one unit but not for people in their rooms or those living on the dementia care unit.

People's care needs were met.

Complaints were responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider made assurances at the last inspection that areas needing improvement would be addressed. However, this had not happened.

The quality assurance systems were inconsistent and ineffective as the registered manager did not have time to complete them.

The staff shared the 'people first' approach of the registered manager and were committed to the home.

People, their relatives and staff were positive about the registered manager.

Roebuck Nursing Home

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We asked the provider to complete a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the action plan the provider sent us following our last inspection detailing how they would make the necessary improvements.

The inspection was unannounced and carried out by two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with 10 people who used the service, six relatives, eight staff members and the registered manager. We received information from service commissioners. We viewed information relating to eight people's care and support. We also reviewed records relating to the management of the service. Some people who used the services were unable to speak with us due to their complex needs therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

When we previously inspected the service on 18 and 23 April 2015 we found that staff did not always work in accordance with safe infection control guidelines and that staffing levels were not satisfactory. At this inspection we found that although concerns in relation infection control had been addressed, issues in relation to staffing remained.

People gave mixed views in relation to staffing levels at the home. One person said, "Sometimes I need help with getting to the commode in the night – I can wait for some time before the bell is answered." Another person told us, "I think the staffing levels on this floor are good – and there is no problem, even at night." Relatives generally thought there were not enough staff. One relative said, "If they had more time with them [people] then they could work even more miracles." Another relative said, "There are not enough carers, they are running about from one to another." A third relative told us, "I do believe they need [an extra staff member] to answer the buzzer when it goes off which is mostly at busy times. Sometimes 10 or 15 minutes and that can seem like a lifetime." We saw that relatives had raised staffing as an issue through an independent survey. However, this had not been resolved.

Assessments of people's care needs were not used to inform staffing levels. For example, there were two staff on the top floor and staff told us that four people living on the top floor required two hourly repositioning. These people were assessed as needing two staff members to carry out the repositioning to ensure it was done safely. This meant that they would require more than two staff to be able to deliver these two hourly positioning for four people in addition to supporting and providing supervision to the remaining seven people, some of whom exhibited behaviour that challenged and were at risk of falling when mobilising without supervision. DoLS applications were applied for these people stating they required constant supervision to ensure their safety. However, this was not possible when staff were unable to be with these people for a period of up to an hour every two hours.

We also saw that people stated in their plans that they preferred to have showers. However, daily notes showed that people were washed in bed each day with very few showers recorded. Staff told us showers took around two staff around 30 minutes where as a wash in bed took one staff member 15 minutes. This indicated that this option was provided to ensure they were able to support people in a timely way. We also saw that morning care was still being delivered at 11am on the ground floor. This meant that staff did not have time to provide one to one activity time with people before lunch as planned. One staff member said, "I love working here, but lately the staffing numbers have made it a nightmare. So many staff have raised issues, activities are not fairly given, [Person] can't go because they may wander and as one of us has to go with them there is not the people to help."

We saw one person become very anxious during lunchtime. The person required a staff member to spend time with them to offer reassurance. However, staff were unable to do so as they were needed to support people with eating and drinking. The same person was later put to bed with both bed rails raised. Staff told us this was done as they were unable to supervise the person to ensure they were safe when they were walking around due to staffing levels. Staff told us that the home had people with high dependency and

complex needs and this made it, "Very Busy." One staff member said, "There is time for all the personal care, but no time for the other stuff, activities and chatting." We noted that staff worked hard to support everyone but as a result they worked constantly.

The home was recruiting for new care staff and nurses and the registered manager told us that they used agency staff to cover shifts when needed. We reviewed the rota and found that most shifts were covered on a regular basis. However, staff told us that they and the registered manager worked several hours to ensure shifts were covered. One staff member said, "I regularly work [extra hours], the money is good I admit it, but it's getting to the point where I need to look after my body." Staff told us they worked extra hours out of loyalty to the home. The registered manager told us that the staff worked very hard and were always busy. They told us that staff on the top floor were instructed to call down to other floors to ask for a staff member to assist them at busy times. The registered manager also told us they were putting together a proposal for the provider to review staffing levels.

Due to our findings at this inspection and that the issues in relation to staffing had not improved since the last inspection we found this to be a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's medicines were not always managed safely or administered as prescribed. People told us they received their medicines at regular times. One person said, "When I first was discharged from Hospital I was in a lot of pain – staff here really helped with that, and I felt better than I had for a long time." However, we found that there were shortfalls in relation to the recording and quantities of medicines. We counted nine boxes of tablets. Of those nine boxes, eight contained the incorrect quantity. For example, one person's medicines were recorded as receiving 28 tablets into the home and 20 tablets had been signed as being administered. A count of the stock showed only three tablets left in stock. The expected amount was eight tablets. This was a discrepancy of five tablets. We were unable to ascertain if the person had received the wrong dose of their medicines or if it was a recording error.

We found that handwritten entries had not been signed by the staff member who made the entry. This meant that handwritten entries were not countersigned to ensure the record was accurate. Countersigning handwritten entries is good practice to ensure that people receive their medicines in accordance with the prescriber's instructions.

In addition we found that where people were prescribed medicines on an as needed basis, information was limited. Although we saw that staff had made entries as to the reason why a medicine had been administered, it was not documented as to when and why they may need this medicine ahead of administration. We also found that there was no direction on how people may take their medicines or the support that may have been required.

Therefore this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they felt safe living at the service. One person said, "I do feel safe here, If I didn't I would soon tell someone." Relatives also felt people were safe. One relative said, "I spent a long time looking for a suitable home for my [person], and as soon as we walked in we knew this was a good home – it just felt warm and safe, and it's turned out to be the right one." Staff knew how to recognise and respond to any concerns of abuse. One staff member said, "[Registered manager] has a zero tolerance on anything like that." We saw that staff had received training on the subject and information was displayed to help raise awareness.

People had their individual risks identified when they first moved into the service and staff were familiar with those risks. However, we also found that in some cases, risks assessments and supporting care plans were not always completed. For example, in relation to falls or moving and handling. We found that where accidents and incidents had occurred an accident form was completed. However, the forms did not allow for a review of the accident, a record of remedial actions if any and there was no record of the event being reviewed to ensure all action had been taken to mitigate the risk. The registered manager told us that this information would all be in people's care plans. However, acknowledged that this may not be completed each time an accident of incident took place.

Although staff had a good understanding of people's needs in relation to individual risks, the lack of consistent and up to date assessments of people's needs was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff employed at the home had been through a recruitment process. This included an interview, proof of identity and a criminal records check. However, the references on staff files were not always from previous employers and were not always verified. In addition, there was no way of checking that staff did not start employment prior to all relevant checks being carried out. We discussed the need of having a log sheet to help ensure all appropriate checks were completed ahead of a staff member starting work to help ensure that people were fit to work in a care setting. This was an area that required improvement.

Requires Improvement

Is the service effective?

Our findings

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, and whether any conditions on authorisations to deprive a person of their liberty were being met that service was working in accordance with the MCA and DoLS guidance.

We found that where people had their capacity assessed, this was not robust and did not assess or identify to what decision it related. For example, assessments asked the initial four questions and a yes or no was checked in regards to if the person had capacity. There was no record stating what decision was to be made or what form of communication should be used to ascertain people's capacity. In addition, some people whose care plans stated they had no communication skills had not received a capacity assessment.

We found that where people lacked capacity, there were no best interest decisions recorded. The registered manager told us that best interest decisions and meetings did not take place. They told us the DoLS were automatically applied for to ensure everyone went through the process to ensure they complied with legislation. However, with no authorisations yet granted and restrictions in place, there were no plans in place to ensure the least restrictive options were being used or control measures in place. For example, where a person was restricted from leaving the building alone, a plan to ensure they had access to going outside or to other units.

We observed staff use bedrails to prevent a person from getting up and walking alone. The person's relative said, "The bed rails are their decision, they need to stop [person] walking around when they haven't got enough [staff] to keep an eye on [person]." Staff told us this was because the person was at risk of falling and they needed to keep them safe. However, they were unlawfully restraining this person as there was no best interest decision made in regards to this course of action and their plan stated only one bed rail was to be used and a sensor mat to alert staff when the person moved around their room.

Therefore we found that this was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they were asked before staff supported them with care. One person said, "Staff do tell me what they are doing and why, and very often they make sure that I am happy with what they are doing." Another person said, "Staff will not do things for me without asking me first." We saw that in most cases that staff asked people for their consent before supporting them and gave people choice. For example, what they wanted to eat. However, we also saw that staff used a frame of another person without asking them to help

another person stand from their chair. The owner of the frame asked, "Please can I have it back." and it was returned.

We also found that on one floor staff were providing support based on what a relative had said rather than what the person wanted. For example, one person was stating that they wanted to sit in their room for meals and was pushing themselves away from the table. We asked staff about this who told us that the person's relative wanted them in the dining room for meals. It was clear that staff were struggling with this as they wanted to respect the person's wishes but also did not want to go against instruction form a family member. This was an area where a best interest meeting would have been beneficial to help ensure the person's preferences and views were taken into consideration.

People gave mixed views about the food, some said they enjoyed it and had plenty of choice where others felt the quality of some of the meat was chewy. We were told by staff that meal choices were taken the previous day but if people didn't want what they had chosen then they would request an alternative from the kitchen. For example, we saw that one person had requested porridge for their lunch and this was accommodated. We also saw that people had access to drinks, and care staff were also circulating to make sure that refills were available. We also saw one member of the care staff noted that a person had not drunk anything from their earlier round – and stayed to assist so that a whole glass of water could be consumed and a full glass was left for them.

The lunchtime experience varied across the home. On the ground floor we saw that people received support to eat and the tables were set in advance. However, on the middle floor we found that some people needed more encouragement than was offered. However we also saw one person eat all of their lunch, ask for seconds of pudding, and was brought an extra portion. The staff told us the person really enjoyed their food, and often had extra and said, "It's good because [person] is on a diet to build [them] up." On the top floor we found that support was stretched due to the needs of the people living there. For example, when one person became anxious and needed one of the two staff members to spend time with them, they had to stop serving up lunch and the remaining people did not receive lunch for over 15 minutes as the other staff member was busy assisting someone to eat.

We also found that prompts to help people living with dementia recognise that it was lunchtime were not in place. For example, the table was not set and there were no menus available. We noted that there were no menus on any of the floors. We also found that colourful plastic beakers were given to everyone, regardless of needs and this did not provide the same experience that a glass may have offered.

The dietary needs of people were displayed on the kitchenette notice boards. For example, diabetic or soft meals. No one received any fortified foods to help encourage sufficient calorific intake and the chef confirmed this. Pureed food was delivered in take away plastic containers and served onto plates and merged together which did not look appetising and people were not told what they were eating. Pureed food was left on top of the hot trolley in the plastic containers for 45 minutes and was not temperature checked at any time.

People did not always have their nutritional needs assessed and had not been weighed. One staff member told us, "It's because we don't have a scale for a wheelchair or a hoist." Another staff member said, "Honestly, weights don't get done every month, there's just not enough time." They went on to tell us that they had not yet started taking other measurements, such as a mid-upper arm circumference to help them identify people's changes in weight. We saw that people who had been assessed as being at risk of not eating or drinking enough had their food and fluid intake recorded and some people had been referred to healthcare professionals as needed. Although we found that people did not appear to have lost large

amounts of weight or become dehydrated, the dining experience and food delivery was an area that required improvement.

However due to the lack of consistency of assessments and weight monitoring this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had regular access to health and social care professionals as needed. One relative told us, "I am impressed with the attentiveness of the staff, I noticed that my [person] had the beginnings of a pressure sore, and mentioned it to a member of the care staff. Within hours the Practice Nurse visited and we had agreed a programme of treatment and action to minimise the discomfort." There was a GP round twice weekly which was very thorough and referrals to supporting services, such as the occupational therapist were also made. We also saw that there was a visiting chiropodist and hairdresser.

People were supported by staff who received appropriate training for their role and who received regular one to one supervision. People and their relatives felt staff were well trained. One relative said, "They are very good, they seem to understand dementia, they both seem to instinctively know what's going on and then how to care for them." Another relative told us, "I feel they know what they are doing."

Staff felt they had enough training for their role. One staff member said, "The training is good, and I feel supported by [Nurse] or [senior staff member] we have our supervisions, they observe me." Another staff member told us, "We are always learning." We saw staff received training in relation to moving and handling, safeguarding people from abuse, infection control and dementia care. We also saw that the service had started working with a training provider to develop champions in key subjects throughout the home. This included dementia, nutrition and falls. The registered manager was an ambassador for training and was committed to the personal development of staff. However, while this benefitted the staff and the home for a period of time, this often meant that well trained staff then moved on to undertake a nursing degree. A staff member said, "The [registered] manager is really keen that we all improve our knowledge and skills, and get as much formal training as possible. One of the biggest problems we have is that once people get a certificate they move on to better paid more responsible jobs in other homes or in hospitals." The registered manager told us this made them happy that staff were achieving their goals but it was bittersweet as the home then lost staff they had invested in. We saw that staff received regular one to one supervision and an annual appraisal. During these staff were able to discuss any issues and training they would like to undertake. The registered manager also used this as an opportunity to assess staff knowledge and to help underpin good practice.

Good

Is the service caring?

Our findings

At our last inspection on 15 and 23 April 2015 we found that records were not always stored securely. The registered manager sent us an action plan stating how they would meet regulations. At this inspection we found that the appropriate action had been taken. Confidentiality was promoted and records relating to people were all stored securely.

People told us that staff were kind and caring. They said they always felt treated with respect and their dignity was prompted. One person said, "The staff here all know me and my little foibles very well. They really are lovely here." Another told us, "The staff know what makes me tick." Relatives also felt that staff were kind and caring. One relative said, "The staff are very approachable, they're happy and enthusiastic." Another told us, "The girls who do the care are very caring." Another relative said, "Staff have a smile on their face every day, even the cook is welcoming and they get on with person so well. They pick up on things, like with person doesn't like loud noises, so they now speak very softly, approach quietly and respect that's his way, they even make sure the TV is on softly."

We saw that all interactions were done so in a way that was respectful and staff knew people well. For example, one person who was living with dementia had dressed in a way that may not have promoted their dignity. The staff who approached them did so in a way that made them smile by telling them they looked fantastic and was responded to with affection by the person. The staff member supported the person by saying, "Can you show me all the other lovely clothes you have? I know you have so many lovely clothes." This was responded to well by the person who happily went to their room to try on different clothes.

Staff also told us that when they supported people to eat, then tended to do this in their rooms. One staff member said, "Sometimes I prefer to assist residents in their rooms, it's better for us and protects their dignity at the same time."

The registered manager and staff knew people well. They were able to tell us about people's life histories and what their preferences were. We saw that each person had a life map and this included lots of details to help their identity be promoted. People told us their felt they were treated as individuals and their cultural and religious needs were met. One person told us, "The [Registered] Manager offered to take me to a prayer house of my choice locally whenever I need it. – I try to go weekly to a small house in Watford as that meets my needs." They told us that their religious dietary needs were also accommodated.

People and their relatives said that at the beginning of their stay they were asked about what they needed and their preferences and their day to day involvement was sought but they were not always involved in the reviews. One person said, "I am involved in my own care – I am always asked whether I want a wash, shower or bath in the morning, and I know that I can choose." A relative told us, "I was fully involved in the [pre-admission] assessment, the family found it difficult, but the staff were friendly and patient, and took their time to listen to us." We found that the involvement throughout people's stay tended to be less formal with most people and their relatives not reading or signing care plans. However, one relative told us, "I don't need to be consulted on every little change – I have confidence in the staff, and anything significant would, I

am sure, would be raised with me." Another relative told us, "They do tell me what they are doing and why – even if I don't need to know."

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not always include information about how they needed to be supported. We saw that some people had plans for needs such as eating and drinking, communication, pressure care and falls, whereas others did not. Some plans were detailed and person centred but other were sparse and only included the basics. Some people with health conditions did not have plans to ensure there was clear information for staff. For example, one person with cancer and another with diabetes did not have plans for this. We also saw that some people did not have end of life care plans, even though they had been admitted for palliative care. We did find that staff were familiar with people's needs and they were confidently able to provide us with information about the people they supported. We saw that staff delivered care in accordance with handover and information passed on by the registered manager.

People living on the ground and middle floor had access to group activities in the afternoon. These included quiz afternoons, gardening, bingo, singalongs and religious services. We saw that these activities catered for the preferences set out in people's life maps. People who lived on the ground and middle floor were mainly positive about the provision of activities. One person said, "I prefer to chat with the other ladies, that's what we do best, but occasionally some of us take part in a quiz or something, but most of us really like to be able to get outside into the garden and have a good chat. The staff take us out and quite often stay with us to chat for a while too." However, people who lived on the unit for people living with dementia did not access these activities. One relative told us, "There are not enough activities, they knew you were coming [CQC] so [person] has painted a plaque, it was just out of the blue, and a one off. There just isn't anything for them, when there is it's like it's a treat, but it should be the norm." We found that people who lived on this unit seemed to listen to music and walk around, if able, with little stimulation. There were limited objects that may stimulate the senses and engage people. Staff told us that in the morning it was part of their role to provide one to one activities for people, in particular those who were cared for in bed. However, they told us that due to being busy this rarely happened but on some days they could sit and chat with people. The registered manager told us that they were currently recruiting for an activities co-ordinator.

Due to the incomplete assessments and plans of care, the improvements needed in relation to the environment for people living with dementia and the lack of meaningful activities in some areas of the home, we found that this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's care needs were met and they were positive about the standard of care they received. One person told us, "I am very happy here. The staff are brilliant, I know I can tell them if I need something and it will happen. They look after me so well, I can't find fault." Relatives were also happy with the standard of care people received.

Staff were responsive to people's needs. We saw one person succumbed to a coughing fit during lunch. We saw staff respond well to this situation, and worked together to reassure the person, who was becoming anxious and said they felt sick. After a very short time the nurse called by to check that all was OK with the person, who was now sleeping, and to also ensure that they had calmed and was able to drink properly. It

was clear that the nurse had been alerted by the care staff, and all was calmed in an efficient and effective manner.

The registered manager was an advocate for people who requested and they chased extra equipment that may help improve people's lives. For example, one person received a new wheelchair on the day of our inspection to help promote their independence and they told us that they were now chasing a computer that was adapted to enable the person to use it independently.

However we found that the environment, in particular for people living with dementia, needed further development. There were no conversation pieces around and the lighting and signage needed improving. There were no visual prompts in regards to rooms and bedroom doors were impersonal. This extended to the availability of menus. One relative told us, "I do think that it would be better for [person] if the food choice could be selected from picture options – sometimes [person] doesn't understand what a particular meal name describes – and if I am not here [they'll] just nod to be polite." The registered manager told us that there was a picture menu available, however, we did not see this being used. There was also no display in communal areas or information in people's rooms about activities that were on offer and prominent clocks to help people orientate themselves. Staff told us they felt people needed a better environment. One staff member said, "There's no dementia stuff here, no lights, boxes, clothes, just nothing for them to do, [Person] would love to use the lights, and [Person] gets agitated when [Relative] leaves, but there's nothing we can do to distract or interest them." The notice board was full of leaflets for staff and advising people about probate and funding with only the odd piece of information about hairdressing and religious service's available. This was an area that required improvement.

People's complaints were responded to appropriately. One person said, "The staff are happy people, and very understanding – and I know they would not ignore me if I was unhappy". Relatives also told us that any concerns brought to the registered manager would be addressed. One relative said, "I feel I can talk to the [registered] Manager and the seniors (staff members) about anything in the home and that they will listen." We reviewed the complaints log and saw that all complaints were investigated and responded efficiently.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found management systems required improvement. At this inspection we found that although some systems had been developed they were not being used consistently or effectively.

We found that there were quality assurance systems in place. However, these were not being used effectively or consistently. For example, at the last inspection this was identified as an area of improvement so the registered manager developed care plan audits. These had been added into care plans. We saw that these had not been reviewed and there was no overview of the audits. The registered manager told us that they had not had time to complete the audits.

We saw that the registered manager was out supporting the team by carrying out medicine rounds and the twice weekly GP rounds. They told us these rounds could take up to 5 hours. The registered manager told us, "I like to be out 'on the floor', I can't do my job from within the office." These rounds alone took a significant amount of time out of the registered manager's working day and this meant they were unable to complete other duties, such as quality assurance. They told us that there was no deputy manager, clinical lead or unit managers employed at the home. They said they had been unsuccessful in recruiting a deputy manager. As a result, they were responsible for all monitoring, checking and auditing of the home as well as providing training and support for staff. We found that this meant that systems they had put into place, such as pressure mattress monitoring, were not carried out correctly. For example, staff were signing to say they had completed the checks but we found that all mattresses we checked were set incorrectly.

Due to the registered manager being spread thinly across the home with little or no management support, staff were not supervised to ensure they always worked in accordance with their training. One relative told us, "In the early days the management were prominent, getting together all the bits and pieces, but now they seem a lot more distant." We saw staff cutting corners with moving and handling. For example, lifting a person under their arms and leaving a hoist sling around one person which impacted on the pressure care management. We spoke with the registered manager about this who told us this practice was unacceptable and was not aware that this was happening..

We spoke with staff about the management of the home. One staff member told us, "The last three months here haven't been good, really not good, and I don't know what will happen if the next three are the same. You have to respect the manager, she gets rid of people if they are not up to scratch but we are really struggling." Another staff member said, "If I have a problem I'll go to Manager, she listens, is strict, but I know where I am with that. She is absolutely strict on fluid charts, incidents, food charts, positioning, care, and if it's not done how she wants it then you will know about it."

Resident and relative meetings were held every three months. Meeting notes showed that the subjects covered included meals, staffing and activities. Although we could see some suggestions had been actioned, for example, tissues in the lounge area, there were no action plans developed to ensure that people's views were responded to. One relative told us, "There are relative meetings that I can go to, in fact there was one the other week that I didn't get to." They went on to say however non attendees do not get minutes of the

meetings.

The registered manager told us that they did not hold formal noted staff minutes. They told us they get groups of staff together, such as the nurses, to discuss key information and provided staff with memos with need to know information. They also said that they, along with the provider, held meeting meals where they were able to get staff views. Staff told us that they had not attended any staff meetings and that feedback was generally given at handover or supervision sessions. We discussed with the registered manager the importance of documenting meetings, along with action plans to help inform quality assurance processes.

Due to the undeveloped and unutilised governance systems, we found that this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager was very passionate about providing a high standard of care to the people living at the home and we found staff shared this view. The commitment to delivering good care was partly the reason for governance systems to have not been effectively used. Staff told us that they were tired and things had been hard but they stayed at the home through loyalty to the registered manager and dedication to the people who lived there.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have clear assessments and plans in place. Activities and the environment for people living with dementia needed improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of MCA and DoLS were not adhered to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels did not ensure all needs were fulfilled.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were ineffective and inconsistent.

The enforcement action we took:

NOP to impose positive conditions