Dryband One Limited

Bradley House Care Home

Inspection report

Bradley Road
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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

Bradley House Care Home is registered to provide residential care for up to 48 older people, some of whom may be living with dementia. All the accommodation is provided on the ground floor. The home is situated on the outskirts of the town of Grimsby. On the day of the inspection there were 34 people using the service.

The service did not have a registered manager in post. A new manager had been appointed in August 2016 and they confirmed they had submitted their application to register with the Care Quality Commission (CQC) the previous week. A registered manager is a person who has registered with 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 2008 and associated Regulations about how the service is run.

We undertook this unannounced inspection on the 21 and 22 February 2017. The last full inspection took place on 22 and 23 October 2015 and the service was compliant in all areas although we rated the service, 'Requires Improvement' to ensure the improvements were sustained. At this inspection we found breaches in four regulations and the service rating remains 'Requires Improvement.'

We found there was inconsistency regarding the application of the Mental Capacity Act 2005. The registered provider and acting manager had not always followed best practice when assessing people's capacity and discussing and recording decisions made in their best interests.

We found not everyone had a full and up to date care plan and risk assessment to guide staff in how to meet their needs in a person-centred way. Staff had not responded to changes in one person's health care needs and action was taken to access a medical assessment following direction from a social care professional during the inspection.

There were shortfalls in the administration and recording of some people's medicines. We also found the medicines for some people admitted for short term rehabilitation support, had been out of stock for a period of time, due to delays in obtaining the medicines. One person had not received their medicines for three days and this was addressed during the inspection. There was no guidance for staff around the use of 'as needed' medicines to ensure consistent administration.

The above areas breached regulations in person centred care, consent to care and safe administration of medicines. You can see what action we have asked the registered provider to take at the back of the full version of the report.

The quality monitoring system had not been effective in highlighting areas where improvement was needed such as the care records, consent to care and the management of medicines. We found action had not been consistently taken or identified in order to address these shortfalls. 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.

We saw there were sufficient staff on duty to meet people's needs. We found staff had been recruited using a robust system that made sure they were suitable to work with vulnerable people. They had received a structured induction and essential training at the beginning of their employment. This had been followed by regular refresher training to update their knowledge and skills. Staff received an appraisal and recent gaps in the supervision programme were being addressed.

Relatives gave us positive feedback about the care and support their family members received. Staff approached people in a kind and caring way which encouraged people to express how and when they needed support. Staff demonstrated good communication skills and distraction techniques when managing people who may need additional support to manage their behaviours.

People liked the meals provided to them and there was sufficient quantity and choice available. We saw people's weight, their nutritional intake and their ability to eat and drink safely was monitored. Referrals to dieticians and speech and language therapists took place when required for treatment and advice. During the day, we observed people were served drinks and snacks between meals.

People's privacy and dignity were respected and staff provided people with explanations and information so they could make choices about aspects of their lives. There were positive comments from relatives about the staff team.

We saw people were encouraged to participate in a wide range of activities at Bradley House and to maintain their independence where possible. Relatives told us they could visit at any time and we saw staff supported people who used the service to maintain relationships with their family.

We found people who used the service were protected from the risk of harm and abuse because staff had received safeguarding training and they knew what to do should they have any concerns.

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 consistently safe.

Some people did not receive their medicines as prescribed.

Staff knew how to recognise and respond to abuse and understood the processes and procedures in place to keep people safe.

Staff were recruited safely and sufficient numbers of staff were provided to meet people's individual needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The application of the Mental Capacity Act 2005 (MCA) was inconsistently applied and the best practice principles of MCA regarding restrictions placed on people had not been followed for each person they applied to.

People liked the meals provided and their nutritional needs were met.

Staff had completed a range of training. Further courses to meet people's individual needs in areas such as stoma care would provide staff with increased knowledge and skills. Staff received an appraisal and recent gaps in the supervision programme were being addressed.

Is the service caring?

Good

The service was caring.

People and their relatives were positive about the way in which care and support was provided.

Staff were kind and caring in their approach. Staff had developed positive relationships with the people they supported and were seen to respect their privacy and dignity.

People who used the service were encouraged to be as

independent as possible, with support from staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

A new care recording format had not been implemented consistently. Some people's needs had not been effectively assessed and personalised plans of care had not been developed to provide full guidance in how to meet them. A shortfall in communicating and assessing one person's changes in need meant a delay in accessing medical attention.

People had the opportunity to participate in meaningful activities.

There was a complaints process in place and on display. People felt able to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Our inspection findings, including breaches of regulation, showed that effective systems to monitor and improve the service were not in place.

Inconsistent management of the service in recent months had impacted on staff morale. Although staff reported improvements with the increased support and direction from the new operations director in recent weeks.

Meetings were held to enable people who used the service, their relatives and staff to express their views about the service.

Bradley House Care Home

Detailed findings

Background to this inspection

This unannounced inspection took place on 21and 22 February 2017 and was completed by an adult social care inspector who was accompanied on the first day by an expert by experience, who had experience of supporting older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed. We also spoke with the local authority safeguarding team, and the contracts and commissioning team about their views of the service.

During the inspection we used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who used the service. We observed staff interacting with people and the level of support provided to people throughout the day, including meal times.

We spoke with twelve people who used the service, six of their relatives and four visiting health and social care professionals. We also spoke with the operations director, acting manager and a selection of staff; these included the three team leaders, the administrator, two care workers, the cook, laundry assistant, domestic and the maintenance person.

The care files for six people who used the service were looked at. We also looked at other important documentation relating to people who used the service such as incident and accident records and medicine administration records. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

A selection of documentation relating to the management and running of the service was looked at. This included three staff recruitment files, the training record, staff rotas, minutes of meetings with staff and

people who used the service, complaints and quality assurance audits. We completed a tour of the building and checked the environment.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe at the service and staff treated them well. The majority of comments about staffing numbers were positive. Comments included, "I feel very secure here, I sleep like a log", "They keep me safe here", "It's nice and clean here, they change my bed every day", "I use my walker inside and I feel safe", "Someone comes with me when I have a shower or bath, it makes me feel safer", "They come quickly when I ring the bell", "They do work very hard. I don't wait a long time. They always they come as quick as they can" and "I don't think there's always enough staff."

Relatives told us, "My mum is well looked after and safe, I have peace of mind with all the staff", "Yes, I feel she's very safe. There are no staff issues here. The fact no-one can get in or out the doors without staff assistance helps", "Staffing levels seem okay", "They could always do with more staff, they do a great job and I will always be thankful" and "It is a big home but there's usually staff around and about keeping an eye on everyone. Some days seem busier than others."

We found safe medicines practices were not always followed, which meant people were at risk of not receiving their medicines in line with prescribing guidelines. When we checked the medicine administration records (MARs) for 34 people we found medicines were not always given as prescribed by the doctor. For example, a person who was prescribed a pain relief medicine every three days had received this medicine a day late on one occasion and two days another time. We found staff were not recording in the correct sections of the controlled drug register and this medicine had not been entered onto the person's MAR. Another person was prescribed an antibiotic medicine to be taken three times a day and on one occasion the staff had administered four doses on one day. Checks on another person's MAR showed the staff had signed for but not administered their medicines on two occasions. We also found medicines had not been given to three persons, admitted to the service for short term rehabilitation support, as the medicines were not available. One person had not had their medicines for three days. The staff informed the person's GP and the medicines were obtained during the inspection.

We found some recording issues where staff had hand written a person's medicine prescription and there was no second signature, to indicate another member of staff had checked the record was correct. There were some gaps on medicine administration records (MARs) when staff had not signed or recorded a code to show when a person's medicines had not been given as prescribed. We also found there was a lack of written guidance to enable staff to safely administer medicines which were prescribed to be given only 'as and when' people required them.

These issues meant there was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

There was a policy and procedure to guide staff in how to safeguard people from the risk of harm and abuse. Staff completed safeguarding training and in discussions were familiar with the different types of abuse, the signs and symptoms which may alert them to concerns and how to refer an allegation to the appropriate

agencies.

We saw people had assessments in place to help guide staff in how to minimise risk. These included falls, moving and handling, nutrition, skin integrity and the use of equipment such as bedrails. Accidents were recorded and analysed to look for patterns; people were referred to health professionals for advice when they experienced repeated falls.

The three staff files we checked showed staff were recruited safely. Each potential employee completed an application form so gaps in employment could be examined. References were obtained and a check made with the disclosure and barring service (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

Our observations, and people's comments, indicated there was enough staff on duty to meet people's needs and keep them safe. The acting manager told us they monitored people's dependency levels and reviewed the staffing levels on a regular basis. On the day of our inspection there were 34 people who used the service, 11 of whom were short term placements. The staffing rota indicated there was one team leader and four care workers on shift morning and afternoon. This reduced to a senior care worker and two care workers during the night. There were separate staff for activities, administration, catering, domestic, laundry and maintenance tasks and the acting manager was supernumerary.

On the first day of the inspection there was a shortfall of one care assistant in the morning due to short notice sickness. The acting manager explained they had not been able to provide internal or agency cover for this shift, however a care worker was requested to attend the late duty earlier than scheduled on the rota, to provide support. We noted the routines were busy and although staff were stretched, they were able to meet people's needs in a timely way. The remainder of the inspection we noted the routines were calm and people's requests for support were made by attentive staff who had time to sit and talk with people and provide support with activities.

Staff we spoke with told us the current staffing levels were adequate to support the needs of the people who used the service. One member of staff told us, "The staffing levels are usually okay, we don't often work short" and another member of staff said, "We use bank and agency staff to cover any shortfalls. We only accept new admissions if we have the staff in place." The acting manager confirmed the number of staff at the service had not kept pace in recent weeks with the number of new admissions (permanent) to the service, they had been using high levels of bank and agency staff but they had now recruited three new members of staff who were due to start work. One new member of staff commenced work during the inspection, shadowing an experienced member of staff for the shift. The operations director confirmed they would be monitoring the occupancy and dependency levels closely to ensure the staffing levels were adequate.

We found the environment was safe and there were systems in place for dealing with emergencies. Each person who used the service had a personal emergency evacuation plan. Equipment used in the service was checked and maintained. All staff were responsible for highlighting any issues which needed repair or replacement and maintenance personnel completed a series of environmental checks; they kept a log of all tasks identified and signed it when they had been completed.

We saw evidence that good standards of hygiene had been maintained and all areas of the service were clean and tidy. There were no unpleasant odours. The care staff had been trained in infection control. They were able to demonstrate a good understanding of their role in relation to maintaining high standards of

hygiene, and the prevention and control of infection. We saw that care staff wore personal protective equipment when delivering personal care and practised good hand hygiene. The acting manager and senior staff mostly understood the recent guidance from Public Health England in relation to the management of an influenza outbreak. The operations director took action during the inspection to ensure staff understood the process to provide people's GP's with relevant correspondence in relation to the use of anti-viral medication, if people presented with colds and coughs.

Requires Improvement

Is the service effective?

Our findings

People told us they were able to access healthcare professionals when needed. They also told us they enjoyed the meals provided by the service. Comments included, "The nurse comes twice a day to give me my insulin. I also have the chiropodist for my feet every six weeks", "I feel so much better since I've been in here. I was very poorly when I came", "They will get the doctor in if you're not well and the nurse comes each day to check I'm making good progress", "Oh, it's very nice food, it's very fresh" and "Today I had boiled eggs done just as I like them-soft."

Relatives told us, "My relative is able to walk now and couldn't do that when they first moved here. They have got physically better, they are happier and more confident", "The staff are always keeping me updated if there are any changes. They would contact the doctor if necessary" and "The meals are well balanced and tasty. Always a choice of main meal and at tea time. It's good home cooking and they provide plenty of fresh fruit and vegetables. I've eaten here too."

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. We found the application of MCA was inconsistent. Whilst we found some people had capacity assessments, and decisions made in their best interests recorded when they lacked capacity, others did not. For example, some people had restrictions in place regarding the provision of bedrails and sensor alarms; however, their capacity to make these decisions and consent to them had not been assessed. Also the decision made to carry out these restrictions, as in the person's best interests, had not been discussed or recorded so it was difficult to establish who had been consulted. A new care record format had been introduced; however, we found few of the records had been completed about the person's capacity to make decisions or family involvement and any legal arrangements in place.

Not working within the principles of MCA in assessing capacity prior to making best interest decisions, is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

In discussions with staff, it was clear they had an understanding of the need for people to consent to care provided. Comments included, "We always ask people about their care and involve them as much as possible in any decisions", "If they can't give consent, we have to act in their best interests and ask their family and the GP" and "We try to reassure them, different faces help people, we would leave them if they refused care and go back later; we don't use physical interventions on anyone."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the registered provider was working within the principles of the MCA regarding DoLS for people who used the service. The acting manager had made

applications for 16 DoLS and these were awaiting assessment by the local authority. We found the acting manager and staff had completed training in MCA and DoLS.

We saw people had access to health care professionals for treatment and advice when required; staff recorded in people's care files when they were seen by a health professional. These included GPs, district nurses, dieticians, speech and language therapists, physiotherapists, occupational therapists, emergency care practitioners, opticians and chiropodists. People had also attended outpatient appointments and been seen by the falls team.

Menus provided choices and alternatives and we observed drinks and snacks were available throughout the day. The cook explained how they provided people with a healthy balanced diet and all meals were home-cooked. They catered for people with diabetes and prepared fortified foods for people who were at risk of losing weight. They also provided soft and textured diets for people with swallowing difficulties. Records showed people's weight had been monitored regularly and the provision of fortified (high calorie) diets for people at risk of malnutrition helped ensure they maintained a healthy weight.

We observed the lunchtime and tea time meal service in the dining room on both days of the inspection. The atmosphere was relaxed. We saw people were offered a choice of meal and staff spoke reassuringly and kindly to people as they supported and encouraged them to eat. People had clothes protectors and plate guards when required. The meals provided looked well-prepared and well-presented and people enjoyed them. Staff were attentive to the needs of people who required assistance.

We looked at the training records for all of the staff who worked at the service and these indicated staff had undertaken training considered as essential by the registered provider. This included fire safety, moving and handling, nutrition, food safety, health and safety, infection prevention and control and safeguarding people from abuse. Staff who administered medicines had completed training and most staff had also completed courses on dementia awareness, mental capacity legislation, dignity, equality and diversity, pressure damage prevention and palliative care. The acting manager confirmed all new staff completed induction training which included the national Care Certificate standards, if they had not previously worked in a care setting. Staff were also supported to achieve a national diploma qualification in care.

The majority of long term staff had received an appraisal, the acting manager explained there were some delays with the completion of the programme, but this was being addressed. We saw staff had access to formal supervision meetings and on-going day to day supervision and support. The structured plan of supervision showed some gaps, however the operations director confirmed a new timetable was being developed and compliance would be monitored through monthly audits. Staff we spoke with considered they had opportunities to speak with their line manager and could approach the acting manager at any time.

We found the renewal programme to the premises had been completed and improvements had been made to the internal and external facilities. The home was brighter, cleaner and more comfortable. People had been consulted about the choice of décor for their room including the colour of the bedroom door.

We saw the premises had been adapted to support the needs of people who lived there. Corridors were wide and had hand rails. Toilets had raised seats and grab rails or over the seat frames. There was appropriate equipment such as a call system, moving and handling items, profile beds, specialist mattresses and cushions and sensor mats. There was some use of contrasting paint colours, photographs on doors and pictorial signage to provide orientation for people living with dementia.

Good

Is the service caring?

Our findings

People who used the service told us staff were very caring and looked after them well. Comments included, "They are very good to me. They look after me well. They couldn't have been kinder, everyone here including the cleaner", "I find them great, very helpful. I really do. Very often we have chats so see how I'm getting on", "The staff are very friendly. They are nice. If there's anything important to talk about you can", "They listen to you. They always have time to listen", "I've felt very welcome here. They always have time for you. The night and day staff are all lovely" and "I like the staff I've got no complaints. I've got to know them I know all their names."

Relatives told us the staff were caring and friendly. One person said, "Carers have been brilliant. They all seem very pleasant." Another relative explained how their family member had been reluctant and embarrassed to accept personal care support from the care staff when they were admitted. This meant they had to visit each day to assist with this care. But, over time their family member had learnt to trust the staff and was now happy to accept care from the staff, who they found to be very kind and caring. This was credit to the staff and their positive approach.

Health care professionals told us, "Staff are friendly, polite and kind. I have often seen choice being offered to residents" and "Staff use good communication skills to interact with service users."

We spent time observing the interactions between staff and people who used the service. We saw staff were kind, patient and respectful to people and people seemed relaxed in their company. Staff spoke with people in a reassuring and caring manner. We watched how staff gently supported a person who had become anxious and upset with doll therapy. We observed a more negative interaction during the first day of the inspection in the lounge; one person frequently called out which several of the other people in the room found to be disruptive and upsetting, although the staff present did not intervene. We mentioned this to the operations director and found this was managed better on the second day as staff engaged people more with activities and conversation. They played bingo and talked about news items, their families and reminisced with people about the local area. The interaction was genuine and both staff and people who lived at the service were heard laughing and sharing stories. The operations director confirmed they planned to introduce staff competency assessments of their care, communication and engagement with people and these would be carried out regularly to support a more consistent staff approach.

Staff understood the importance of respecting people's privacy, dignity and encouraging independence. In discussions they said, "We always explain everything we do and give people time to do as much for themselves as they can", "We have a lot of respite clients who need support to return home. We help them to do what they can and give them confidence and encouragement to regain their skills where they can" and "We knock on doors, keep doors and curtains closed and cover people up as much as possible to keep them warm and comfortable during personal care."

We saw people were discreetly assisted to their rooms for personal care when required. Staff encouraged and supported people to change their clothing where necessary after meals and snacks. We observed staff

took time to listen to people; they encouraged people to speak for themselves and gave people time to do so. One person told us, "Yes your privacy is always respected. They close the doors and curtains if they're getting you dressed or undressed."

We saw people were provided with a range of information. There were notice boards in the entrance areas with information about the organisation such as inspection reports and rating, activities, dignity awareness, safeguarding adults from harm and how to make a complaint. There was a photograph of each member of staff and there were leaflets available, for example on advocacy. The acting manager told us the local advocacy services were not providing support for any person who currently used the service.

Care files and other private and confidential information were stored safely. The registered provider's computer systems required personal log in and password details to gain access and staff confirmed that confidentiality was covered in their induction. This helped to ensure unauthorised people did not have access to personally sensitive information.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they could participate in activities when they chose to and also that they would feel comfortable raising concerns with staff. Comments included, "Oh, the activities lady is super. She makes this place. She does puzzles, a quiz makes you use your brain", "We play bingo and do all sorts of crafts", "We get our hair done weekly and she does our nails", "If I've any problems I speak to the senior carer. She gets it sorted" and "Any complaints are dealt with straight away."

Relatives of people who used the service told us they would have no hesitation in raising concerns. One person's relative told us, "We asked about a TV for their bedroom and asked if they could sit in the lounge more. The next day they had a TV and were sat in the lounge. We were very happy" and another relative said, "Once I complained about something to the senior and it was rectified straight away."

Visiting professionals considered the standards of care were inconsistent at times. They said, "Staff know people well but the basic care can be inconsistent at times. Sometimes it depends which staff are on and things can get missed", "There have been some teething problems with the new care plans which they are addressing" and "We have had to follow up on skin care for one person recently to make sure staff were repositioning the person and completing skin checks regularly."

We found there was an inconsistency with assessments of people's needs and care plans to meet them. Some were completed fully and others had important information missing. We found people had an assessment of their needs prior to or on admission; there was also an assessment of their dependency level which was reviewed monthly. Risk assessments were completed but on some documentation checked we found anomalies, which could have affected the risk score and more attention was needed for accuracy. On some occasion's risk assessments were not in place, for example, one person did not have a risk assessment for bedrails.

Although some people had person-centred care plans, this was not the case in all the people's care files we assessed. A new care recording system had been introduced but in some files we found the old records had not been removed and some of the new records were blank. Some people did not have care plans for specific health needs and when care plans were in place they did not consistently contain sufficient information to guide staff in how to meet people's needs in a person-centred way. For example, one person had a urinary catheter but there was no specific plan to manage this. Another person did not have a care plan to direct staff on how to care for their stoma and we found care records showed there had been regular problems with the integrity of the stoma bag. Senior staff we spoke with provided specific guidance on the care required but we found this was not recorded anywhere and not all staff were aware of this. Three people's care plans for personal hygiene were not person-centred. One person's care plan for mobility and risk of falls had not been updated for two months, yet they continued to experience a number of falls.

During the inspection a social care professional reported a concern in relation to their client's care support. The person who used the service had been admitted for short term enablement support and experienced a recent change in their health, which caused them discomfort and anxiety. Although the person had

discussed their concerns with a care worker their changes in need had not been fully assessed and discussed with the community nursing staff or the person's GP. Checks on their care records showed minimal assessments of need had been completed. The concerns about the person's health condition resulted in the person attending their GP and admission to hospital for assessment. The operations director commenced an investigation during the inspection into staff not responding to changes in the person's health and wellbeing and gave assurances that all concerns would be addressed.

We found one person had anxieties and regularly demonstrated behaviour which challenged the service. There were a number of behaviour management plans in their file which contained limited direction for staff such as, 'Provide support and reassurance', however there were no details about how this was to be completed. Therefore staff did not have clear direction about positive strategies to be used.

Not ensuring people's needs were accurately and consistently assessed, care planned and met in a person-centred way was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the registered provider to take at the back of this report.

The operations director explained how they were in the process of introducing another new care recording system because they thought the one recently put in place did not enable staff to provide the accepted level of person centred information. They confirmed the acting manager had completed the records for one person using the new format and we checked this during the inspection. We found the records were detailed, covered all areas of need and contained relevant person centred information. The operations director confirmed they would be arranging for managers of other services within the organisation to provide further training on person centred care planning for the care staff and provide appropriate resources and direction for senior staff to complete the work.

The service employed a full time activities co-ordinator and people were encouraged to join in a range of social and leisure activities. A log was maintained of activities and each person had their own profile, 'My life journey', this included best memory, working life, hobbies, favourite food and places they had visited. There was a range of activities people could participate in which included painting, manicures, baking, bingo, quizzes, games, crafts, dominoes and visiting entertainers. Relatives confirmed they were invited to activities and events held at the service and during the inspection we saw people going out with the families and friends for meals and shopping trips.

We saw the service had a complaints procedure on display. This told people how to make a complaint and how to escalate it if they were unhappy with the outcome of any complaint investigation. The staff had access to a complaints policy and procedure to guide them in how to manage complaints. This included letters for acknowledgement and forms to record the details of the complaint, investigation and outcome. Records showed that when complaints were received, the management had followed the registered provider's policy to ensure the issues were managed appropriately and resolved. During the inspection one person raised a concern about the attitude of some staff when they used their call bell and we passed this on the operations manager to look into and address.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us they felt confident in the management of the service, although some people were not sure who the manager was. They told us, "I think the home is managed well; the facilities are nice and well maintained and we are very pleased with the care", [Name of manager] is usually around if I need to speak with them about something and "I may have met the new manager, I'm not sure."

The service had undergone continued management changes during 2016. The previous manager had left in April 2016 and the new acting manager had been appointed in August 2016. The operations director had also recently resigned and a new operations director had been appointed three weeks prior to the inspection. In that time the care record format had been changed twice and a new quality monitoring programme had been purchased but not implemented. Staff described a very positive team approach but felt the recent changes in home manager and at senior level had led to conflicting management approaches and some confusion. They felt they had not always received the necessary support and direction they had needed to properly implement the new quality monitoring and care recording systems. One member of staff told us, "There has been a lot of changes with the care records, we are now on the third change in a year. Morale is a bit up and down." Another member of staff said, "The manager is very supportive and quite hands on, but it's been confusing with the changes in the care records and now we are putting in another new system, although it does seem better."

There was a basic quality monitoring system in place and regular audits had been undertaken, but we found aspects of the programme were not effective. For example, the recent audits of medicines systems had identified few issues, yet we found a range of concerns. There were no checks carried out on the recording and administration of controlled medicines within the audit system and shortfalls were identified. Some people had not received the medication they were prescribed due to staff error or poor stock control. In August 2016 the pharmacy provider had completed an audit and found issues in relation to some medicines being out of stock and some recording shortfalls and these shortfalls were identified on this inspection. We also found shortfalls in the quality of the care records and records to support consent to care, which had not been identified through the audit programme. In February 2017 the community matron for tissue viability had completed an audit of records to support pressure damage prevention, the findings of the audit showed the service had scored 61%, which indicated improvements were required.

Not ensuring the service had a robust quality monitoring system was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

We saw accidents and incidents were recorded and collated each month to see if any improvements could be made. We saw action had been taken when people had experienced falls such as a referral to the falls prevention team and the provision of a sensor alarm to alert staff. We found the prevalence of accidents was recorded, although the information about location and timings could be included to better identify any patterns or trends. Records to support the monitoring of people's weight loss were found to be effective. The

community infection control nurse had recently completed an audit of infection prevention and control systems at the service and the findings had been positive.

Meetings were held for residents and relatives in order to gain their input and views of the quality of the service. People who used the service, their relatives, staff and professionals were also involved in completing questionnaires about their experience of the service and any improvements they would like. We found the results of recent relative surveys in December 2016 were generally positive about the service and these had been published on notice boards in the entrance hall.

There were regular meetings and shift handovers to ensure staff had up to date information about issues affecting the service and people who lived there. Staff were able to participate in the meetings, express their views and make suggestions.

The operations director gave assurance that the shortfalls identified during the inspection would be dealt with as a priority and provided action plans following the inspection. They also confirmed they would ensure appropriate support would be provided to the acting manager and senior staff at the service in developing their management skills to ensure the improvements were sustained. The operations director explained the recruitment of new care staff was a priority which they were addressing.

We saw the registered provider and acting manager were aware of their responsibilities in notifying the Care Quality Commission and other agencies when incidents occurred that affected the safety and wellbeing of people who used the service. We received these notifications in a timely way.

The service had undergone assessment by North East Lincolnshire Clinical Commissioning Group in 2015/16 where quality standards were reviewed within the authority's Quality Framework Award. Overall, the service had met the criteria for a 'Bronze' rating which indicated the service used best practice but could improve in a few areas.

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 who used the service did not consistently have their needs accurately assessed, care planned and met in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments and records of best interest decisions were not in place to support staff were acting lawfully in relation to aspects of people's care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured people who use services were protected against the risks associated with unsafe management of medicines.

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 Effective systems or processes to assess, monitor and improve the quality and safety of the services provided and mitigate risk had not been operated fully.

The enforcement action we took:

We issued a Warning Notice.