Southwark Park Nursing Homes Limited

Blenheim Care Centres

Inspection report

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Date of inspection visit:
09 August 2016

Date of publication:
22 September 2016

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Blenheim Care Centres on 9 August 2016. The inspection was unannounced.

Blenheim Care Centres is a nursing and residential care home for up to 80 people located near Gainsborough, West Lincolnshire. The care centre is divided into three units, Blenheim House, Blenheim Lodge and some semi-independent flats. Blenheim Lodge was closed for refurbishment on the day of the inspection.

The home caters for people whose ages range from 18 years and above, and who have physical disabilities and/or neurological conditions. On the day of our inspection there were 36 people were living at the care centre.

A newly appointed manager was in post who had not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission (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 found five breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because registered provider did not have systems in place to ensure people who lived in the home received their medicines in a safe and timely manner. Risk assessments were not always recorded or reviewed in a robust manner. In addition, the registered provider had not effectively risk assessed the environment people were living in and taken action to address any issues highlighted. All of these problems resulted from the registered provider not operating a system of robust quality checks.

Further shortfalls involved the registered provider not employing sufficient numbers of staff with the appropriate skills to ensure people's health, safety and welfare needs were met. Arrangements for assessing people's capacity to make decisions and those decisions taken in people's best interest were not always carried out or recorded in a robust manner. These breaches had reduced the registered provider's ability to ensure people were kept safe. You can see what action we told the registered provider to take at the back of the full version of this report.

People received the personal care they required from staff who understood how to provide the care. They were supported to make their own decisions and choices on a daily basis. However, people were not provided with consistent or suitable support to engage in meaningful activities or to develop their personal interests.

People were treated respectfully and with dignity by care staff who ensured their privacy was maintained when they provided personal care. However, people's privacy and dignity was compromised because the registered provider had not always considered these issues in the way they managed the home

environment.

People's care plans did not set out clear guidance as to how their needs should be met and they had not benefitted from being involved in developing or reviewing the plans. This increased the risk that agency staff or newly appointed staff would not have a clear understanding of people's needs and how to support them. In addition, people had not benefitted from staff who were appropriately supported carry out their roles or encouraged to keep up to date with best practice methods.

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.

Medicines were not managed in a safe way.

Risks to people's health, safety and welfare were not robustly managed.

There were not enough staff to ensure people reliably received the care they needed.

Arrangements for security, housekeeping and maintenance of the building were not robustly managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The legal requirements of the MCA were not always followed in a robust manner.

People did not always receive the healthcare support they required.

Staff had not received all of the training and support they needed to carry out their roles.

Arrangements for ensuring people received the nutritional support they required and wished for were not always carried out in a robust manner.

Permanently employed care staff understood people's personal needs and how to manage those needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's privacy and dignity was not always respected in the way the home environment was managed.

People were treated in a kind and caring way by staff.

Staff understood the need to maintain the confidentiality of people's personal information.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Arrangements for ensuring people were involved in planning or reviewing their care were not always robust.

People were not fully supported to engage in meaningful activities of their choice.

The registered provider's complaint procedures were not effectively managed.

People received the basic personal care they needed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems were not robustly managed and did not reliably identify or resolve shortfalls in the way care was delivered.

Arrangement for receiving feedback about the way the service was run were not effective.

Staff were not supported to receive or act upon good practice guidance.

Blenheim Care Centres

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 registered provider was 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 9 August 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and a pharmacy inspector.

Before the inspection, we asked the registered provider to complete 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 registered provider returned the PIR and we took this into account when we made our judgements in this report.

We looked at the information we held about the home such as notifications, which are events that happened in the home that the registered provider is required to tell us about, and information that had been sent to us by other agencies such as service commissioners.

We spoke with nine people who lived in the home. We looked at six people's care records and we also looked at the medicines administration records for 17 people. We spent time observing how staff provided care for people to help us better understand their experiences of care.

We spoke with three members of care staff and a registered nurse. We also spoke with the manager, the deputy manager and the registered provider's area manager. We looked at three staff recruitment files, supervision and appraisal arrangements and staff duty rotas. We also looked at records and arrangements for managing complaints and monitoring and assessing the quality of the service provided within the home.

Inadequate

Is the service safe?

Our findings

We found that medicines were not always managed safely. Some medicines were prescribed to be given as and when people required them (PRN). There were no PRN protocols in place for people informing staff when to give the medicine. This meant that people may not be given their medicines consistently and at the times they needed them. When PRN medicines had been recorded as being given we did not see details of the reasons for administration so it would not be possible to tell whether the PRN medicine had the desired outcome for the person receiving it.

Some medicines were prescribed with a variable dose, for example one or two tablets to be given. We saw that the quantity given was not always recorded. This meant that staff could not be sure of the total dose a person had received therefore the person may be at risk of receiving too much or too little of the medicines.

In seven of the medicine administration records (MAR's) we saw there were signature omissions for administration. We also identified five medicines where the quantity remaining in the home did not tally with the original quantity recorded at the start of the month and the number of doses given. Both of these issues meant we could not be assured that people had received those medicines.

Four people needed to have their medicines administered directly into their stomach through a percutaneous endoscopic gastrostomy tube (PEG). We found that the necessary safeguards not were in place to administer these medicines safely. There were no written protocols in place to inform staff how to prepare and administer these medicines. Although the nurse we spoke to described an appropriate process this was not documented. Therefore there was a risk that different staff could prepare and administer the medicines differently and that people's health and welfare could be affected.

The provider's medicines policy required signatures and dates for all amendments to MAR's. Where amendments had been made to MAR's we did not see that these had been signed and dated which meant we were unclear who had recorded this and when the change had occurred.

Body maps had recently been introduced to show where and when people's prescribed creams should be applied. However, when we looked at the records for one person we found that the MAR recorded that the cream should be applied twice daily but other records indicated that the creams were not being used. A person's skin may become dry and sore if creams are not applied as often as the prescriber intended.

The fridge temperature log was only consistently recorded for nine days prior to our inspection. Where the temperature was recorded, the readings indicated the maximum temperature exceeded the safe levels for medicines requiring refrigerated storage on each of these days. This indicated these medicines may not have been suitable for use.

We found that records relating to the assessment, management and review of risks to people's health, safety and welfare were not consistently completed or reviewed for accuracy. Three people required nutrition and medicines to be administered via a PEG tube. The risks associated with the use of a PEG tube were not

clearly identified within care plans. Neither the care plans nor the MAR's included sufficient information about how medicines should be administered via a PEG tube. In addition, best practice guidance for staff as to how to administer nutrition via a PEG tube were not clearly recorded. One care plan did not clearly set out the correct process for flushing a PEG tube before and after the administration of medicines via a PEG tube. We could not find evidence to confirm that this part of people's care and treatment had been regularly reviewed.

Some risks to people's health, safety and welfare had been identified, for example, risks of pressure on people's skin and nutritional intake. The records indicated that the assessments of these risks had been updated but they did not indicate what date they had taken place. There were no clear management plans in place to guide staff as to how they should reduce the identified risks.

Shortfalls in the systems for managing medicines had increased the risk that people would not receive their medicines in a safe and consistent manner. In addition, shortfalls in the way risks to people's health, safety and welfare were assessed, managed and reviewed increased the risk that people may receive inconsistent care and treatment that did not meet their currently assessed needs.

This was a breach of Regulation12 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and the area manager said there were suitable arrangements in place to ensure there were enough staff available at all times to meet people's assessed needs. However, the majority of people we spoke with did not agree with this view. One person told us that staff were "hopelessly overworked and rushed." They went on to describe how their personal care was affected and said, "The staff just can't get to me in time." Another person told us that they received all of the care they needed but it was often delayed. They said two members of staff had previously been allocated to support people living in the semi-independent flats; however this had now been reduced to one member of staff. They added that this member of staff was often called away to support colleagues in other areas of the home. A further person told us they were concerned about the lack of staff presence in the lounge area on most days. They told us, "The staff are too busy and too hectic elsewhere and so we're just left."

The manager and the area manager told us there was a high use of agency staff to fill vacant posts. We looked at staff duty rotas for July and August 2016. The rotas indicated that all of the registered nurse cover was provided by agency staff. The registered nurse on duty was responsible for administering medicines to all of the people who lived in the home, in addition to the nursing care required by 18 people. We saw during the inspection that the morning medicines round took approximately two and a half hours to complete and included the administration of medicines via PEG tubes. The registered nurse told us this was the usual amount of time taken to complete the round. This meant that some people experienced a delay in received their morning medicines. One person told us they sometimes did not receive their morning medicines until approximately 11:30 am. We checked their MAR which indicated that medicines were prescribed to be given at 8:00 am.

On the day of the inspection duty rotas indicated that in addition to the registered nurse there were four permanent care staff and an agency carer scheduled to work. However, the manager told us there had been a mix up with agency bookings and sickness, which meant that there were only three care staff and a registered nurse on duty until approximately 10:00 am. Staff told us that extra staff were not always available at short notice. One staff member told us about a recent shift where they were worked with only two other carers and a registered nurse. They told us, "Some days it's just chaos." Another member of staff commented that there were regularly unfilled shifts, meaning they had to work short-handed. A further

member of staff described the service as 'frantic' with not enough staff. They spoke about times when people had to wait until mid-morning for assistance to get up.

One person who lived in the home told us they did not like constant changes of staff and added, "It's particularly bad when there are two or more agency staff on at night. Another person said, "No staff or you don't know who the staff will be on each day. Faces turn up I've never seen before and then you don't see them again."

We were unable to establish which agency care staff were booked to work on which days as the rotas did not always record their names or times of work. The rotas also did not clearly identify that the levels of staff the registered provider said were necessary to meet people's needs were on consistently on duty.

Shortfalls in the way duty rotas and staffing levels were managed increased the risk that people would not safely receive all of the care they needed and in a timely manner.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and area manager told us that two housekeeping staff were employed within the home. In addition a maintenance worker was available although did not work exclusively within the home. The main building was large and laid out across three floors. As well as people's bedrooms and flatlets there were two large communal lounge areas, a large dining room and a number of bathrooms and toilet areas. In addition there was a large reception area, two staff offices, a clinic room and a staff room. We saw that one housekeeper was on duty each day. This meant that not every area of the home could be cleaned to an acceptable standard within the housekeeper's daily working hours.

During a tour of the building we noted that an upstairs corridor and one bedroom did not have a fresh smelling atmosphere. We also noted a number of fly catching devices were hanging from ceilings in people's bedrooms and communal areas, each of which contained numerous dead flies. In one flatlet we noted a heavily stained lounge carpet and stained kitchen doors. In another flatlet we noted a stained and dusty lounge carpet, a heavily stained shower cubicle and windows which were leaking water on to the window sills. In one walk in shower area we found there was damage to the floor which compromised the registered provider's ability to ensure it was cleaned effectively.

We found that the registered provider had not consistently protected people's personal safety. This was because there was a security issue relating to managing access to the home. We raised this matter with the manager who said that action would be taken to resolve the problem.

In addition, we noted that the flooring in the passenger lift constituted a significant trip hazard because there were raised areas in the flooring and a raised seam. A ramp to enable wheelchair access and egress for the garden area was not suitably fixed which caused it to move when used. Furthermore we found that an automatic fire door was held open with a plastic wedge. We also saw that two bedroom doors were held open, one with a bin and another with a piece of string tied to a sink tap in the room. This increased the risk that people would not be suitably protected in the event of a fire. In one bedroom we noted a radiator was not correctly fixed to the wall and was leaking water on to the floor.

Shortfalls in the arrangements for security, housekeeping and maintenance of the building meant that people could not be assured they would receive care in a safe, clean and suitably maintained environment.

This was a breach of Regulation 15 (1) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for recruiting new staff to work in the home. One staff file we asked to look at was not available in the home on the day of the inspection. The three staff files we looked at showed that a number of background checks had been carried out. The registered provider had carried out Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with people who lived in the home. They had also checked areas such as employment history and obtained references from previous employers. However, the checks had not always been carried out in line with the registered provider's policy. The registered provider said they would obtain two references for prospective staff members regarding the previous employment conduct and character. However, in two of the files we looked at only one reference had been obtained. We did not see any evidence that the registered provider had identified these errors during the recruitment process. In addition, there was no information to show that the registered provider had checked the recruitment processes undertaken by agencies for the staff they provided to the home. This meant that the registered provider had not obtained all of the necessary assurances they said they needed to establish a person's previous good conduct.

During discussions with staff they demonstrated their understanding of how to report concerns for people's safety using the registered provider's policies and procedures. They also knew which external organisations they could report concerns to such as the police, the local authority and CQC. There was a limited amount of information within the home for people who lived there and staff to refer to if they had any safety concerns. However, the information was not clearly displayed which meant that people may not know where to locate it.

During the morning of the inspection the manager was able to obtain two extra agency care staff to provide cover for the day's shortfall in staffing levels. We saw that this enabled the staff team to meet people's basic personal care needs for the rest of the day. We saw, for example, that people who required support to manage pressure on their skin were helped to move regularly; people who required assistance with continence were supported in a timely manner; and people who required the use of hoist to move around were supported correctly. We observed the length of time people had to wait for their call bells to be responded to. Prior to the extra care staff commencing duty we saw some people had to wait for up to 15 minutes before their call was responded to. Following the extra care staff commencing duty we saw that no-one had to wait longer than five minutes for their call to be responded to.

Medicines were stored securely. This included controlled medicines which required specific arrangements for storage. These types of medicines also required specific arrangements for recording their stock levels and administration, which we found staff carried out correctly. Medicines with a short life span were dated when opened to enable staff to correctly identify when they became no longer suitable for use.

Requires Improvement

Is the service effective?

Our findings

We were told that some people who lived in the home did not have capacity to make important decisions about their lives for themselves. Each person had an assessment document within their records in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, the assessments gave only a brief indication of the person's capacity but did not fully reflect the type or range of decisions each person could or could not make for themselves.

In addition, people's care plans did not fully reflect the type or range of decisions each person could or could not make. They did not contain clear guidance for staff about how to support people to make decisions and choices for themselves. Nor did they clarify how people communicated their decisions and choices. Furthermore, records did not show that people had been involved in the assessment of their capacity to make decisions for themselves. We found only one of the personal records we looked at contained evidence to show where decisions had been taken in the person's best interest. This meant that people, or those who lawfully acted on their behalf could not be assured that their capacity to make decisions had been suitably assessed or taken into account when care was planned. During the inspection we saw people were supported to make their own decisions and choices about topics such as what they wanted to wear and where they wanted to spend their time.

People told us they could see their GP when they needed to and records showed that where people needed support from community nursing teams this was in place. However, people's records did not clearly show when people had been referred for specialist healthcare support. An example of this was a person who had diabetes and who experienced fluctuating blood glucose levels. There were no records to show staff had referred to specialist healthcare professionals in order to help the person better manage their condition. In care plans for people who had diabetes there was no indication of how staff should manage raised or lowered blood glucose levels or which healthcare professionals should be contacted for advice.

Shortfalls in the way people's capacity to make decisions for themselves had been assessed and managed meant that they could not be assured that all of their legal rights would be maintained. Furthermore, the way in which people's healthcare was managed meant that people could not be assured they would receive all of the care they required.

This was a breach of Regulation 9 (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recently appointed staff told us they had received induction training when they started to work at the home. However, there were no records to show the training had taken place or to indicate the quality of the training. The manager and deputy manager were aware of the nationally set standards for induction training but the system had not yet been introduced in to the home. In addition, there were no records available to demonstrate that agency staff received an induction to the home before they commenced working in the home.

A matrix was in place to show what on-going training staff had undertaken. However, this was incomplete and did not show that all staff had undertaken the training the registered provider said was essential such as moving people safely and health and safety topics. Furthermore it did not clearly show that staff had received training in how to manage people's specific needs such as diabetes or providing nutrition by way of a PEG tube. Some training certificates were available in staff files but they were not consistent with the information contained in the training matrix. In addition, there were no records to show the training that agency staff had received. This increased the risk that people may receive care that was not effective in meeting their needs.

Records were available to show that some staff, but not all, had received formal supervision and topics discussed included record keeping and medicines errors. However, we could not clearly establish that the staff we spoke with had received effective supervision within the previous two months. The manager told us they were reviewing the supervision and appraisal arrangements to ensure all staff had regular access to this support.

The people who lived in the home and the staff we spoke with commented that the lack of preparation agency staff had prior to starting their shift meant that permanent staff had to spend time showing them what care was required and how to carry it out. One person who lived in the home told us, "They [agency staff] just don't know what they are doing and care is delayed."

This meant the registered provider could not be assured that all of the staff who provided care for people living in the home had the appropriate skills and knowledge to carry out the roles expected of them.

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

Throughout the inspection the permanently employed care staff we spoke with demonstrated their knowledge and understanding of people's needs and how to meet them. They also correctly described, for example, the use of moving equipment and the use of different continence and pressure relieving aids. We saw that they applied this knowledge and understanding when caring for people. We also saw that they asked people for their consent before they provided care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest 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 found that four people were subject to a DoLS authorisation and we saw that the conditions of the authorisation were being met. People's care records indicated that they had been consulted about and agreed to the use of equipment such as bed rails and wheelchair lap straps in order to reduce the risk of them from having accidents.

On the day of the inspection there was no permanently employed chef. We saw that the deputy manager was undertaking this role. We were told that the deputy manager had received training about food hygiene but had not received training about how to ensure that diets provided were nutritionally balanced. Although the deputy manager knew about people's preferences for food there were no clear records available to demonstrate this information. A nationally recognised nutritional assessment was in place in the personal records we looked at. However, there was no indication of when or if they had been reviewed. This meant that staff may not be able to clearly identify if a person required additional support with their nutrition. In addition, there were no clear management plans in place to guide staff as to how they should support people to receive their nutrition. This increased the risk that people may not receive the nutrition they needed.

On the day of the inspection we saw that people received the food choices they preferred at the breakfast and lunch time meals. Portions were of a size that people told us was satisfactory for them and they received drinks as and when they required or requested them. However, some people commented that the quality of the food served was variable and depended upon who cooked the food. The manager told us that they had begun recruiting for a new chef and an agency chef would be employed in the interim to cover the shortfall. Permanently employed staff we spoke with were able to describe the signs of under nourishment and dehydration and the steps they would take to address any issues they found.

Requires Improvement

Is the service caring?

Our findings

The registered provider had not always considered people's privacy and dignity in the way they managed the home environment. Examples of this were observed in respect of the security of the home and the cleanliness of the home. We also saw that some people's bedrooms contained an open toilet and sink area. Privacy screening was in place in some bedrooms. However, in one bedroom we found no privacy screening in place. In addition, we saw that the privacy screening provided did not afford people full privacy or fully maintain their dignity. This was because the screening consisted of a light weight material that did not reach the floor. However, people's dignity and privacy was maintained during all care based interactions we observed with staff. Examples we saw were the nurse responsible for medicines administration seeking people's consent before administering medicines; people were addressed by their preferred name and the nurse demonstrated that they were aware of people's preferences for receiving their medicines. Staff made sure that personal care was carried out in private areas with doors and window curtains closed. When people wished to discuss personal issues staff ensured they were afforded a private space in which to do so.

We saw people were supported to dress in a manner they preferred and chose, and they had a choice of whether they were supported by male or female staff. One person said, "My help is done by ladies how I like it." One person told us that care staff took time to speak with them about their preferences for personal hygiene but they told us they did not wish to take the staff's advice and staff accepted this. Another person told us that care staff consulted with them about their care and were helpful. At various times throughout the inspection we saw people laughing and having jovial banter with care staff.

People we spoke with told us that care staff were kind and caring. They made comments such as, "The staff are kind enough" and "The staff are very kind." They made further comments about care staff being helpful and doing their best to support them. However, four people told us they found the attitude of some senior members of staff to be less than kind and helpful. They told us about their experiences of interactions they had with some senior staff and described their responses as "rude" and "ignorant." We spoke with the manager about this following our inspection and they gave us assurances that they would address the issues. People also told us they had opportunities to express their views during house meetings. However, they said they felt that some senior members of staff did not actively listen to their views and rarely acted upon any suggestions they made.

There was limited written information available within the home regarding advocacy organisations. This meant that people may not have the information they needed to make contact with an advocate should they need to do so. Advocacy organisations can provide people with support to express their views and opinions and are independent of the care service registered providers.

During the inspection we saw that people's personal information was stored in an office which was locked when not in use. Staff demonstrated their understanding of the need to maintain people's personal information in a confidential manner when we spoke with them. They knew that this information should only be shared on a 'need to know' basis with those whom people had agreed to share their information with.

Requires Improvement

Is the service responsive?

Our findings

Each person who lived in the home had a care plan in place. However, the care plans we looked at did not give clear guidance about how people's care requirements should be managed. Examples of this were seen in care plans for people who used catheters to aid continence. The plans did not clearly show how catheters should be monitored and maintained. In the care plans for people who needed to have pressure relieved on key areas of their body to prevent damage to their skin, there was no clear indication of how often they should be supported to move or what equipment they required to help them.

Despite the shortfalls in care planning arrangements, on the day of the inspection we saw people were supported to relieve pressure on key areas of their body in a timely manner. They were supported with their continence in a timely manner and equipment such as hoists and pressure relieving bed mattresses were in place and used correctly. In addition, CQC records and the records within the home did not indicate that the incidents of pressure ulcers were unduly high. People we spoke with said that their basic care needs, such as washing and dressing were met. However, the shortfalls in care planning meant that people were at increased risk of not having their care needs and wishes met in a consistent manner. This was particularly due to the high use of agency staff who may not know people's needs and wishes and would rely on care plans to guide them. One person told us, "They [staff] always change and so half the time the staff don't know me."

People we spoke with knew that they had care plans but said they did not know much about them. Care plans did not record who completed them and when they were completed. In addition there was no indication within the care plans that people had been involved in developing them. Monthly reviews of the care plans had been recorded but they contained no information to indicate that people had been involved in the reviews. In addition, the review records did not clearly show how the review had been conducted and only stated the outcome of the review. This meant there was no information to show how the outcome had been arrived at.

People we spoke with told us there were very few activities to motivate or stimulate them during the day. One person who was in their bedroom told us, "I do go downstairs to have a change of scene but on most days there's nothing at all to do just sitting around." Another person said that although they were not interested in joining in with activities, they found the lounge area "depressing" because people just sat around all day doing nothing. A further person told us they were fed up living in the home because they spent all day wandering around and not quite knowing what to do. A person told us there used to be activities in the home but now there was usually nothing to do. During the inspection we met one person who had been supported with their hobby of painting pictures and one person who was supported to follow their football hobby. A regular group exercise session also took place during the afternoon which was facilitated by a visitor. The manager told us that they did not currently employ any staff members who were able to focus on supporting people with stimulating activities and developing their hobbies. However, they told us they had begun advertising with a view to recruiting an activity co-ordinator.

People told us that if they had a complaint they would speak to the care staff or the manager. However, they

told us they had little confidence that their complaints would be addressed or resolved. People told us they had in the past complained to senior staff members about, for example, the condition of the home environment, the lack of staff and the quality of food. However they told us they had seen few improvements. We found there was limited information around the home to guide people in using the registered provider's formal complaints procedure. The complaints that people told us they had made were not clearly recorded within a complaints log so we could not see how the registered provider's complaint policy had been used to address their concerns.

Requires Improvement

Is the service well-led?

Our findings

The Provider Information Return (PIR) that we received prior to this inspection indicated that there were robust arrangements in place to regularly check the quality of the care and services people received. During the inspection we were only able to establish that quality checks had been carried out in June 2016 for areas such as kitchen hygiene, meals and nutrition, infection control and the provision of care. An audit of the medicines arrangements had been carried out in August 2016 in response to concerns raised by a stakeholder. However, apart from the medicines audit we did not see that the results of the audits had been evaluated and action plans had not been created to address any highlighted issues. In addition, we noted that audits had not identified any of the issues we found during the inspection such as the shortfalls in medicines arrangements, care planning and record keeping, staff training, staffing levels and the security and maintenance of the environment. The manager told us the registered provider and the area manager visited the home regularly. However, we could not establish that they had monitored or reviewed the effectiveness of quality assurance systems during their visits.

The PIR indicated that people had opportunities to provide feedback about the way the home was run and the services they received. People we spoke with told us they attended meetings with senior staff. We were told that a meeting had been held in June 2016 for people who lived in the home and their relatives. There were no recorded minutes of these meetings available to us during the inspection so we could not establish what type of feedback people had provided or how they had been responded to. One person told us their feelings about the meeting saying, "They're [senior staff] polite enough but you can tell nothing will be done." During the inspection we could not establish if there were any other means by which people could give the registered provider their feedback such as, for example, surveys or questionnaires or comment cards.

The registered provider could not demonstrate that steps had been taken to support specific members of staff to undertake lead roles in areas such as infection control, promoting health skin or nutrition. In addition, we could not establish that staff had been provided with the leadership necessary to enable them to engage with national initiatives such as the 'Social Care Commitment'. This meant that staff did not have consistent resources within the team to guide them with up to date and best practice methods of providing care for people.

Shortfalls in the systems for assuring quality had reduced the registered provider's ability to ensure people received safe, effective and responsive care.

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post. However, a new manager had been appointed with a view to them registering with CQC. The new manager had been in post for seven days on the day of our inspection. They demonstrated a clear understanding of their role and the responsibilities they would have when they registered with CQC.

Staff told us there were some arrangements in place to support them to carry out their roles. These arrangements included supervision sessions and staff meetings. However, they told us that they did not feel supported by the arrangements or by senior staff. They were aware of the registered provider's arrangements for whistleblowing but said they had little confidence in the process. They described staff morale as being low. We saw the minutes of a staff meeting held in June 2016. Topics such as care planning, fire safety and the environment of the home were discussed but there was no indication that staff had been able to express their views about the service or that their views had been listened to. The manager told us they were reviewing the supervision and appraisal arrangements to ensure all staff had regular access to this support.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured that people's capacity to make decisions had been suitably assessed and that all of their legal rights would be maintained. In addition, the registered provider had not ensured people reliably received all of the healthcare they required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had not ensured that people would receive their care in a safe, clean and suitably maintained environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured that quality assurance systems were reliably managed so as to enable them to identify and resolve any shortfalls in the services provided for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured that sufficient numbers of suitably skilled and

experienced staff were employed to meet people's needs in a safe and consistent manner.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered provider had not ensured that people would receive their medicines in a safe and consistent manner. In addition, the registered provider had not ensured that risks to people's health, safety and welfare had been suitably assessed, managed and reviewed.

The enforcement action we took:

Warning notice regarding medicines arrangments and risk assessing.