Ultima Care Centres (No 1) Limited

Green Acres Care 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Green Acres Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Green Acres Care Home provides accommodation and nursing care for up to 62 older people. At the time of the inspection there were 39 people living at the home, the majority of whom had complex nursing needs.

This inspection took place on 27 and 30 November 2017. The first day of the inspection was unannounced. This was the first inspection since the new registered provider had taken over the service in June 2017.

There was a manager in place who had started the process to register with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The governance systems were not robust. Although action was taken where some shortfalls were identified, there was a failure to adequately assess all aspects of the service and take appropriate remedial action. Some of the improvements that had been made were not sustained. A number of records kept for the monitoring and planning of people's care were inaccurate, incomplete or not up to date. This meant the registered provider could not be sure people received the care and support they needed.

The systems in place to make sure that people were supported to take medicines safely were not sufficiently robust. Medicine records were maintained but these had not always been used in line with relevant guidance. Auditing processes had not identified areas of medicines practice that required improvement.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, relevant legislation had not always been followed and consent for care and treatment had not always been sought from the relevant person.

People were not always treated with dignity and respect by the care staff who supported them. Care plans were in place for each person who used the service. However, these had a lack of information about people's individual preferences and how staff should provide person centred care.

There was an activity programme in place but this was not always followed. Some people told us there was a lack of interesting activities which engaged and stimulated them.

People were supported to maintain their health and had access to health services if needed.

Risks to people in relation to their needs had been assessed. Staff were confident about how to protect

people from harm and what they would do if they had any safeguarding concerns. The manager maintained a clear record of accidents and incidents which gave them an overview of any trends.

The environment was kept clean and safe. Equipment was checked to make sure it worked safely and operated properly.

There were sufficient numbers of staff on duty to make sure people's needs were met. Recruitment procedures made sure that staff had the required skills and were of suitable character and background to work with older people. Staff told us they were supported in their roles and could meet a manager to discuss any issues.

People were provided with sufficient amounts of food and drink. Where people required support with eating or drinking, this was appropriately provided, taking into account people's likes and dislikes.

People's needs were reviewed and appropriate changes were made to the support people received if required. However, risk assessments contained limited information about how risks should be reduced.

Complaints had been properly investigated and responded to. People had opportunities to express their views, although there was no formal way of gaining people's feedback.

This is the first time the service has been rated Requires Improvement under the new registered provider.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Need for Consent, Safe care and treatment and Good governance. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines were not managed safely.

There were sufficient numbers of staff to provide the support people needed. Recruitment procedures were robust.

Accidents and incidents were investigated and monitored to prevent reoccurrence.

Is the service effective?

Requires Improvement

The service was not always effective.

Care and treatment of people who used the service was not always provided with the consent of the relevant person.

People were able to get support from healthcare professionals when needed.

People were offered a range of meals which they enjoyed.

Care staff did not receive supervision in line with the registered provider's policy.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

There was a lack of information in care plans about how people could be involved and encouraged to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans lacked information about people's individual preferences.

People were able to make a complaint and these were properly investigated by the registered provider.

There was a lack of meaningful and stimulating activities.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems for checking the quality of the service and identifying areas for improvement had not been effective.

Records had not been maintained accurately to make sure people received appropriate care.

Green Acres Care 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 and 30 November 2017 and was unannounced on the first day.

The inspection was carried out by one adult social care inspector, a specialist advisor 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. The expert by experience for this inspection had experience of supporting older people.

Before the inspection we sought feedback about the service from Leeds City Council commissioning and safeguarding teams, and Healthwatch. We reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is legally required to send us as part of their registration with the CQC.

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

During this inspection we looked around the premises, spent time with people in their rooms with their permission, and communal areas. We looked at records which related to people's individual care. We looked at four people's care planning documentation, seven medicines records and other records associated with running a care service. This included recruitment records, the staff rota, notifications and records of meetings.

We spoke with eleven people who received a service and four relatives. We met with the regional manager, manager and deputy manager. We also spoke with two nurses, three care staff, the cook, maintenance

person and activity worker.

Requires Improvement

Is the service safe?

Our findings

We looked at the arrangements for the management of medicines. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

We looked at the management of controlled drugs, which are medicines which may be at risk of misuse. Controlled drugs records showed the stock balance was checked on a daily basis and was correct. Controlled drugs were stored safely.

We observed a nurse administering medicines. They explained to people what medicine they were taking and why. People were given the support and time they needed and offered a drink of water. Staff checked that all medicines were taken before signing the MAR.

There was a risk of people not being given medicines safely and as prescribed. For most people that had 'as required' medicines there were protocols in place about when they might need to be offered or administered. However, for one person who had an 'as required' liquid pain relief medicine there was no guidance in place. We noted that some MARs did not make clear the maximum dose to be taken. Two people had medicines crushed before administration, but there was no record of having checked with a pharmacist or doctor that this was safe to do. The regional manager told us they would explore this with the relevant professionals.

Some people required thickening agents to be added to foods and liquids to bring them to the right consistency or texture, so they could be safely swallowed due to a risk of choking. In 2015 an alert had been issued to care homes due to the death of one person in relation to thickening agents. We saw that the thickening agents were stored on the top of people's bedside cabinets, which meant they were not stored securely.

Medicines which required cool storage were kept securely in a locked fridge. Fridge temperatures were recorded each day. However from the beginning of September 2017 until the end of November 2017 we saw that the temperature recorded was over eight degrees centigrade for 70 out of 91 days. This is higher than recommended for cool storage and action had not been taken by staff to ensure medicines were safe to use. This meant that the effectiveness of medicines may have been compromised, as they had not been stored under required conditions.

The issues highlighted above meant that there was not proper and safe use of medicines. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 - Safe care and treatment.

Risks to people were identified through the care planning process. Documents to promote people's safety included the completion of risk assessments, which detailed the risks to each person and the action taken to reduce them. Although risk assessments were kept up to date and reviewed each month, these were in 'tick box' form and lacked detail.

There was a robust system in place to make sure new staff had the right qualities to care for older people. The manager told us they had not recruited any new staff since the provider had taken over the service in June 2017. We reviewed previous staff recruitment files and saw that appropriate checks had taken place before employees started working at the service. We were subsequently informed by the director of operations and compliance, that two staff had started since June 2017.

The manager showed us the process for recruiting new staff. This included an application form and two references, one from the last employer. They told us that if it was not possible to get a previous employer reference they would ask for two character references. A criminal background check was requested from the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about criminal records and those who have been barred from working with vulnerable children and adults. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people. The manager explained that new staff would not be allowed to work until a DBS check and two references had been received.

The manager told us they had a full staff team at the time of our inspection. They said there were usually three nurses and eight care staff on duty. The staff rota confirmed this. The manager explained there was a higher dependency upstairs but there was not a formal way of calculating staffing levels. They commented, "We know staff and residents and what we need".

Although we found no issues in relation to staffing levels, we recommend the registered provider explores the use of a formal dependency and staffing assessment tool.

The service was supported by ancillary staff including domestics, cooks and maintenance staff. The people and relatives that we spoke with raised no particular concerns about staffing levels other than, "They are short of staff some days due to illness". We noted that agency staff were used on occasion, to cover absence.

We looked at the records of accidents and incidents since June 2017. The manager kept a monthly overview of incidents which helped them to identify any trends or patterns. The overview included the actions taken by the service. For example, one person fell three times in October 2017. Actions included a review of the falls risk assessment, physiotherapist advice and care plan update. There were also increased observations by care staff and a referral to the falls team. We noted that all falls were followed up with observation checks, which were recorded. The deputy manager told us that if a person had three falls in a month they were always referred to the falls team for advice.

There were robust checks on the environment to make sure it was safe for the people that lived there. There were up to date test certificates for the fire system, lift, electrical wiring, portable appliances and gas safety.

The service employed a maintenance person to check the safety of the environment. We spoke with this staff member who showed us the records they maintained. These included daily call bell checks, weekly tests of water temperatures and monthly bedroom checks which included beds, window restrictors and lighting. They told us, "It has changed for the better lately. Better organisation. If I need any equipment it is provided".

The maintenance person was responsible for maintaining fire safety which included weekly checks on the fire system, equipment and fire doors as well as daily fire escape route checks to make sure they were clear. They told us they carried out weekly fire drills, for day and night time, to test staff response times. They added that there had been an improvement from 11 minutes to two minutes since they started.

There were up to date safeguarding policies and procedures in place which detailed the action to be taken where abuse or harm was suspected. Staff had received training in keeping people safe, and they told us they were confident about identifying and responding to any concerns about people's safety or well-being. We noted there had been three safeguarding alerts in October 2017 which related to allegations of neglect. These had been reported to the appropriate authorities and investigations had been completed or were ongoing.

Each person had a Personal Emergency Evacuation Plan (PEEP) in place. These are used to make sure staff are aware of the level of support people required should the building need to be evacuated in an emergency.

All parts of the home appeared clean and well maintained. We did notice a strong odour in a corridor, coming from one person's bedroom. We asked a member of care staff about this who told us it was because of the occupant's behaviour sometimes, and it was managed as best possible. We observed staff used protective equipment such as gloves and aprons, when needed, to prevent the risk of infection. To support this, there were hand sanitisers around the building.

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 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 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.

Information on people's capacity varied in care plans. Consent to care and treatment records were not always signed by people where they were able to do so. For one person who did not have capacity, mental capacity assessments and best interest decisions had not been completed for their care and treatment. For example, personal hygiene, nutrition, tube feeding and mobility. The MCA says a person's capacity must be assessed specifically in terms of their capacity to make a particular decision.

On the second day of the inspection, the regional manager showed us the amendments they had made to the person's care plan which had reverted to previous care documentation and contained the required information. The regional manager told us they had also submitted an application for a DoLS authorisation for this person, which had not previously been completed.

We looked at the DoLS monitoring sheet maintained by the manager and found it to be confusing. One person's name had changed to a different name later on in the spreadsheet. In addition, the date the authorisation was received and the expiry date were incorrectly documented. This meant people were at risk of being deprived of their liberty without legal process. The regional manager told us they would arrange for the spreadsheet to be updated.

Some care plans included 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. However, for two people, their previous home address was recorded on the form rather than the care home address. This meant the information was incorrect. We discussed this with the manager who told us they would make sure this was corrected. Another person's DNACPR was reviewed by the doctor in June 2017 and stated it was 'valid until end of life' with no explanation. We noted that records showed it was last discussed with the person in October 2014. There was no evidence to show why the person had not been consulted since this time or whether they still lacked the capacity to make the decision for themselves.

The issues highlighted above meant that care and treatment of people who used the service was not always provided with the consent of the relevant person. The registered provider had not acted in accordance with the Mental Capacity Act 2005.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014,

namely - Need for consent.

Care staff and nurses told us they generally felt supported in their roles. Staff had access to training which the registered provider considered essential to meet people's needs and keep them safe. This included moving and handling, safeguarding and health and safety.

A training and development programme was in place and this showed scheduled training would take place in December 2017. We looked at the training overview maintained by the manager. This showed a number of gaps in staff training, such as, only 11% of staff had completed care plan training and 2% of staff had undertaken mental capacity training. The manager told us that when the previous provider had handed over, they were informed that staff training was at 98% but they had not been given training records or certificates to evidence this. There was a training programme in place but the provider had no accurate overview of staff training needs and had not taken steps to address this.

Staff told us they were supported by the management of the service. Staff received a regular supervision with a senior, where they could discuss any work performance and any issues. Annual appraisals had been carried out for eight staff in 2017. An appraisal is a formal meeting with a manager to review performance, progress and to agree goals for the year ahead. The manager told us that these were in progress as the registered provider had only taken over the service in June 2017.

People's records contained a pre-admission assessment to consider people's needs before they moved into the service. This assessment made sure that staff could meet people's needs and the service had the necessary equipment to ensure the person's safety and comfort. For one person we saw that their pre-admission assessment had noted that there was a query regarding the person being barrier nursed as they had a bacterial infection whilst in hospital. When we discussed this with the manager and the regional manager they told us that they were unaware of this and would explore it further.

Some people who used the service were at risk of pressure ulceration. Assessments had been carried out to identify which people were at risk of developing pressure ulcers and preventative pressure relieving measures were in place for those people who required them. People had detailed care plans to inform staff of the intervention they required to ensure their skin remained healthy. Care plans evidenced access to the tissue viability nurse to assess people's skin condition and provide specialist support on what was needed in terms of care and pressure relieving equipment, to minimise the risk of skin breakdown.

We looked at how people were supported when they were at risk of malnutrition. The cook told us they were made aware of weight loss and that people who had their food and drink monitored were given red tableware, "So that staff were aware". A Malnutrition Universal Screening Tool (MUST) was used to assess the level of risk to people of malnutrition and dehydration. However, for one person we saw their MUST risk assessment score indicated they should be started on a food and fluid chart for three days and then to be weighed weekly. The person had last been weighed a month previously and food and fluid charts were not in place.

People we spoke with told us that generally, the food provided was good. Comments included, "The food is really lovely, although I didn't like the spaghetti bolognaise", "The food is good by and large. We had lovely gammon yesterday and had a super curry the other day, but we don't get as much choice as we used to" and "The food's not bad".

We observed lunch in the dining room on the first day of the inspection. Care staff informed people of the meal once they were seated and offered a choice of two options. Some people told us they did not always

know what was on the menu beforehand. One person said, "I have no idea what we are having until they come round". We noted menus were displayed in pictorial form on each floor. However, there was no menu on display on the blackboard in the dining room, and no menu on tables as agreed as an action point at a kitchen meeting in August 2017.

People seemed to enjoy their food and most ate it all. An alternative was offered if people wanted something else, such as an omelette. Care staff sat down with people who needed support to eat and drink. People were unable to help themselves to juice and water as these were not on the table. A drinks trolley came round during the meal and people were offered refreshment. However, there was no option for people to help themselves and promote independence.

We spoke with the cook who confirmed food was freshly cooked and that people had an alternative. They told us, "I often speak with people and ask about food. We used to have food forums. I want to do more of that". The cook maintained a list of each person's preferences, allergies and special requirements, for example, vegetarian or soft food diet. One person was provided with Kosher food because of their religion. The cook told us, "I introduced a book to record likes/dislikes, type of food, allergies and birthdays. It's a work in progress". The cook showed us a board in the kitchen with a list of each person's dietary requirements and explained that staff gave them a dietary form when there were new admissions.

One person was being fed via a Percutaneous Endoscopic Gastrostomy (PEG) tube. A PEG is a procedure to place a feeding tube through the skin and into the stomach to give the nutrients and fluids needed, where people are not able to eat or drink by mouth. The care plan detailed clear information about the feeding regime, positioning, fluid intake and output, together with care of the PEG tube and routine skin care.

Care staff worked with various health and social care agencies and sought professional advice, to ensure people's individual needs were met. People's care records showed details of appointments with, and visits by, health and social care professionals.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback from people and their relatives about whether the service was caring. Positive comments from people included, "Its lovely here. The staff are so lovely and kind and treat everyone with respect. They come and talk to me if they think I am a bit down. It's a nice atmosphere" and "We are looked after very well. Everything's okay".

Other people expressed concerns, such as "They are not unkind but they are not caring. It's different when [name of care staff] is on. She knows what she is doing" and "Sometimes the cleaners and laundry people are more caring and helpful than staff". One person talked about night time and told us, "I dread the night time. When I see [names of two care staff] I can feel confident. Some of the night staff are arrogant".

On both days of our inspection we felt the atmosphere in the service was flat and lacking in warmth and humour. The manager told us it was quiet because most people stayed in their rooms either through poor health or individual choice. Two people we spoke with commented on this and said, "The lounge is full of emptiness and coldness" and "I feel I was conned into this (placement). There used to be warmth, but now it's cold. Cold care." We observed at lunchtime there was also a lack of atmosphere during the meal. The room was very quiet and there was very little conversation, either with people or care staff.

People were not always treated with dignity and respect by care staff. During one afternoon we saw a staff member going round the bedrooms with a tea trolley. They called out from the corridor to ask what people wanted, rather than approaching people individually to speak with them. On another occasion we saw one person being taken to lunch in their wheelchair. The staff member made no attempt to engage in conversation and did not interact with the person at all. One person told us, "It was gorgeous when I first came here. I idolised the staff. I loved them. They have all gone. I don't think so much of them now. They don't bother with you. I would like them to talk to people; they say they are busy but I can hear them talking".

We recommend the provider assesses the interactions between staff and people to ensure that people are treated with dignity and respect, and they are made to feel important and valued.

Positive observations included the approach of two care staff who were assisting a person to move from a chair to a wheelchair. They did this with appropriate cheery conversation, gentle prompts and encouragement. At lunch we saw a member of staff who displayed a good approach with people; talking at eye level, encouraging them to eat and asking if they wanted condiments and where they wanted them on the plate.

We looked at how people were encouraged to maintain independence and make decisions about day to day activities and routines. People's care plans were not written in a person-centred way and did not promote the need to involve people in decisions about their care. For example, there was no information to show one person's ethnicity or cultural needs had been considered. There were no life history documents and a tick box approach was used to record people's interests. This meant care staff were not provided with

sufficient information to enable them to have meaningful conversations with people.

The manager and activity coordinator both told us they spoke with people about what they wanted to do during the day but that most people chose to stay in their rooms. However, a number of people we spoke with told us they would like to do more, or what was offered was of no interest to them.

Requires Improvement

Is the service responsive?

Our findings

Following an initial assessment, care plans were developed for people's daily needs such as physical well-being, diet, mobility and personal hygiene. These gave information about how people's needs were to be met and gave staff instructions about the frequency of interventions.

The manager informed us that care plans were in the process of being updated onto new paperwork. We noted some care plans still used the previous registered provider's forms. Care records were generally up to date and had been reviewed on a monthly basis. However, review comments were minimal and impersonal. For example, the mobility assessment review for one person simply stated, 'mobilises with zimmer (a walking frame)'. This meant, staff did not have information about the specific details of how the person moved around.

People's care plans were not written in a person-centred way and did not promote the need to involve people in decisions about their care and promote their independence. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to them.

Care records did not contain details about the person's life history and things that were important to them, such as particular events or family information. Care records contained a tick list approach for assessments, social interests, hobbies, religious and cultural needs. For example one person's interests were ticked as television and sport, with no detail about what type of sport or television programme they liked. This meant that care staff did not have the information they needed to meet people's individual preferences.

We looked at the records for one person who had a number of wounds which were being treated. The treatment plan was unclear, not detailed and did not evidence the description of the wounds, the progress which was being made, together with observations to be made should the wounds deteriorate. We discussed this with the manager and a nurse who agreed the plan was unclear. The manager said the wound care plans would be re-written.

The service supported people at the end of their lives and provided palliative care. The service worked with a local palliative community team to provide appropriate support to people. There were end of life care plans in place, where needed, but these contained limited information about the preferences and wishes of individuals and their loved ones at this important time. We expressed our concerns about one person's end of life care plan to the regional manager and manager who reassured us the plan would be reviewed and updated immediately.

Another person's care plan had a written entry by a palliative care nurse on 30 October 2017, which stated, "To have the person's last wishes in writing". There was no evidence this had been completed. We spoke to the nurse on duty who immediately contacted the palliative care nurse regarding this.

The failure to maintain accurate and complete records to support people who use the service, is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014 – namely, Good

governance.

We received mixed feedback about the activities on offer at the service. Comments included, "[Activity coordinator] has taken me into town and had lunch at M&S. We visited my cousin and she took me to Otley. She brightens my day" and "We have bingo on a Monday. I love Bingo. [Activity coordinator] is a lovely lady. She does my nails every week". However, this person added, "We don't do anything else".

Other people told us, "I would like to get out a bit. I don't think the staff here take people out", "I don't want to go to the lounge as they are all asleep and it's not much fun. So I stay here (in the bedroom)", "They don't seem to do anything. I played dominoes once but it was like watching paint dry. I'm surprised they don't have music. It's nice to have music" and "I don't know of any activities". One person said to us, "I'm going mad. There's no one to speak with. No socialisation".

On one occasion we observed four people in the downstairs lounge. They were all sat in wheelchairs waiting for an activity but there were no staff around. We did note that later they were taken over to a tree to help decorate it. On one morning the activity was to watch a film, although we observed a number of people appeared asleep and some would not have had a view of the television from where they were placed. People went to lunch before the end of the film, which was left running. We noted that when wheelchair users were in the lounge they were not transferred onto more comfortable furniture, despite this being highlighted in a memo to nurses in October 2017.

We spoke with the activity coordinator who said it was difficult to engage people in activities as most people were nursed in bed. They added that they spent time sitting with people in their rooms but often they were asleep. The activity coordinator told us that they would be doing craft on one afternoon, but they were not sure if anybody would come as they didn't like craft. Although there was an activity calendar, it did not reflect the activities we saw taking place. For example, on one morning the calendar said there was baking, but this did not happen.

We recommend the provider revisits the activities provision within the service to ensure that it is appropriate to all people's needs.

A complaints procedure was in place which detailed how people could raise a concern. This was displayed on a noticeboard in the reception area. The procedure included contact details of the Local Government Ombudsman and Care Quality Commission, should people want to share their concerns elsewhere. People were not provided with separate information about how to complain and the notice in reception was not obviously visible which meant people may not be aware of it. The people we asked said they would talk to care staff or the manager if they had any concerns.

There was a detailed record of complaints which showed there had been four complaints about poor care practice in the last three months. Records showed there had been a proper investigation and a written response from the registered provider. Any shortfalls had been accepted and an apology offered where appropriate. Responses made clear what action had been taken to make sure there was not a reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

The manager had been at the home since October 2017 and had started the process to register with the Care Quality Commission, which is a legal requirement. They told us that there had been a number of issues at the service, some of which had been apparent before the new provider had taken over. They added that this was a work in progress. They told us, "We need systems in place. We are currently reviewing our systems. We are working on quality standards". The manager talked about what drove them to succeed and explained, "We are here for the service users. Everything is to benefit them. I am a hard worker and need something to do".

When we asked what changes and improvements the manager had made they told us, "We have completed audits of medicines and care plans and started observations and supplementary charts. We had a nurse meeting in mid-November and have 'flash' meetings every day with all the nurses and heads of department". The manager talked about their priorities; "There's a lot to do with care plans. We are focussing on complex needs and audits. We will be changing our medicines pharmacist as there have been problems. Staff morale is okay. There were lots of actions from the last nurses meeting".

The deputy manager felt that the service had improved and said, "We are keeping up with new paperwork and working on morale. There are new procedures. It is slowly getting better. The previous provider was not too supportive. It is easier to communicate with this provider. Priority is nursing documentation. Care for the most part is good, but there is always room for improvement".

We looked at some of the records of meetings and noted a supervision memo was sent to all nurses in October 2017. This stated a number of improvements that needed to be made, which included, seating wheelchair users in a comfortable chair when in the lounge and having two signatures on handwritten medicine records. We found issues with both of these instructions during our inspection. This meant that required improvements had not been maintained and this had not been identified in any of the auditing of the service.

At the start of the inspection the manager told us there had been some complaints about the attitude of night staff. This was highlighted at a nurse meeting in September 2017 by the provider. A recorded comment made by the regional manager stated, "We are aware of the problems on nights and we are dealing with the issues". However, at this inspection, we received negative comments from staff and people who used the service about night staff. One staff member said, "I feel the night staff are not very sociable. They are less respectful to residents. Managers should check on night staff. People sometimes say they didn't press a buzzer because they didn't want to because of night staff. I have told the manager".

We spoke with the manager about this who told us, "I come in early to talk with night staff. We have not had a full team meeting yet but I have met all the staff". The deputy manager said, "There haven't been any night checks since we (provider) took over, but I have come in earlier". The continued concerns meant there had been a failure to make the required improvements.

The manager and provider carried out a number of checks and audits to monitor the quality of the service. An action plan had been produced in July 2017 shortly after the provider took over the service. Where improvements were required an action plan was in place together with a date for completion. Although some of the actions had been completed, such as improvements to the environment, there remained some issues which had gone past the required timescale. For example, care plans were to be transferred to new paperwork by 30 October 2017 (a deadline that had been extended). At our inspection, this work still had not been fully completed. One member of staff had received no training in care planning, although the deadline for this had passed.

There were weekly and monthly medicine audits. We saw that a weekly medication audit had been conducted on 24 November 2017. This showed that fridge temperature records had been checked. However, the audit had not identified the issues we found in relation to these temperatures being too high for safe storage. The audit had identified areas for improvement and an action plan was in place, but there was no signature or date to show when actions had been completed.

The manager told us the regional manager visited the service twice a week to carry out audits and meet with the manager. We viewed reports which the regional manager had completed and these included care plan audits and a monthly home visit report. The home visit report included any feedback received from discussions with people who used the service. This demonstrated people had opportunities to express their views, although there had been no formal resident meetings.

The staff we spoke with told us they had opportunities to speak with the manager or regional manager. Improvements to some aspects of the service had been noted. One staff member told us, "It was heading down but the new manager is on top of everything". The last full team meeting took place in July 2017. Staff told us that were smaller team meetings to share information, as well as the 'flash' meetings at the start of the day and nurse meetings. However, there had been no formal quality assurance surveys sent out to staff or people who used the service and their relatives, since the registered provider had taken over.

We identified a number of records which were either inaccurate, incomplete or not up to date. These included risk assessments, medicine records, care plans and training records. This meant the registered provider could not be sure that people had received appropriate care and treatment.

The issues identified above meant that the registered provider did not have effective governance, including quality assurance and auditing systems or processes. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014, namely – Good governance.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered provider could not be sure that care and treatment of people who used the service was provided with the consent of the relevant person. Regulation 11.

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	There was not proper and safe use of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider did not have effective governance systems in place, including quality assurance and auditing systems or processes. Some records, including a record of the care and treatment provided to each person, and of decisions taken in relation to the care and treatment provided were not accurate or complete. Regulation 17(1)(2).