Quantum Care Limited

Providence Court

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

This inspection was carried out on 17 October 2017 and was unannounced. At their last inspection on 31 January 2017, they were found to not be meeting the standards in relation to management of medicines and the overall management of the service required improvement. At this inspection although we found that the registered manager had made improvements in relation to management of medicines, however we found that they were not meeting all the standards we inspected.

Providence Court provides accommodation for up to 61 older people, some of whom live with dementia. The home is not registered to provide nursing care. At the time of the inspection there were 56 people living there.

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

People, relatives and staff felt that the management of the service needed improving. There were quality assurance systems in place; however these had not identified the issues found on inspection. Improvements were needed on how feedback was sought from people and their relatives and responded to.

People, relatives and staff felt that the lack of permanent staff was an issue. People felt safe but staff were not clear on how to report safeguarding concerns externally. Individual risks to people`s well-being were assessed but there was a risk of these not being adhered to by staff.

People did not always receive prompt support from health professionals in relation to reviews and updates to medicine needs. We found that people enjoyed their food but some people needed more support than they received. Staff were trained but there were mixed views about if they felt supported. People were supported in accordance with the principles of the Mental Capacity Act 2005.

People's dignity and comfort was not always promoted and people were not involved in planning their care. However, people and their relatives told us staff were kind. We saw some positive interaction between staff and people. People were encouraged to make day to day choices where staff felt they were able.

People did not always receive care that met their needs and their care plans did not always include person centred information. Activities did not take into consideration hobbies and interests people had and were infrequent. People and relative knew how to make a complaint but felt they were not always listened to.

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.

People, relatives and staff felt that the lack of permanent staff was an issue.

People felt safe but staff were not clear on how to report safeguarding concerns externally.

Individual risks were assessed but there was a risk of these not being adhered to by staff.

Medicines management had improved.

Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not always receive prompt support from health professionals.

People enjoyed their food but some people needed more support.

Staff were trained but there were mixed views about if they felt supported.

People were supported in accordance with the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and comfort was not always promoted.

People were not involved in planning their care.

People told us staff were kind.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive care that met their needs.

Care plans did not always include person centred information.

Activities did not take into consideration hobbies and interests people had and were infrequent.

People and relative knew how to make a complaint but felt they were not always listened to.

Is the service well-led?

Requires Improvement

The service was not well led.

People, relatives and staff felt that the management of the service needed improving.

There were quality assurance systems in place, however these had not identified the issues found on inspection.

Improvements were needed on how feedback was sought and responded to.

Providence Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

The inspection was unannounced and carried out by two inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with 11 people who used the service and five relatives to obtain their views on the service people experienced. We spoke with eight staff members, the deputy manager, the regional manager and the registered manager. There was also a member of the provider's quality team as part of the feedback session. We received information from service commissioners and health and social care professionals. We viewed information relating to six people's care and support. We also reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person said, "I am safe here, they [staff] look after me." Another person told us, "I am very safe here and there's no worries – at least nothing I can't live with." Relatives also felt people were safe. Staff told us that they would report any concerns about people's safety or welfare to the care team managers. However, most staff we spoke with were unable to tell us how they would report concerns outside of the home. Only one staff member told us that they had information about how to report externally. We noted that there were no visual prompts around the home about how to report concerns and safeguarding people from abuse was not a standard agenda item at meetings.
Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly to take account of people's changing needs and circumstances. Risk assessments were in place for such areas as the use of wheelchairs, falls and mechanical hoists. We saw one person emerging from their bedroom doorway suspended via a mechanical hoist. The staff members told us that there was insufficient room within the person's bedroom to support the person to transfer from their bed to their reclining armchair via means of the mechanical hoist. This meant the person was subject to the risk of banging their legs and feet in the doorway whilst they were turned around to sit in the armchair. Staff told us that a larger room had become available but that they were not aware if the person would be able to move into it. We also noted that a person at risk of choking, whose risk assessment stated they must be elevated to eat, was assisted to eat their breakfast while lying down with only their head slight raised. We noted that their neck was at an angle which made swallowing difficult and may have increased the risk of choking. These were areas that required improvement.
We also noted some instances of some poor infection control practices. For example, a person was holding a used glove; we asked the staff to tend to this. The staff member took the glove and washed their own hands but not the person's, who then started to eat their sandwiches. We also saw a staff member come out of a bedroom after providing personal care, wearing gloves, holding the person's hand. They then went and removed their gloves and washed their hands. The person was not given the opportunity to wash their hand even though they had been held with dirty gloves and they were then given a sandwich to eat.
Due to staff not all being aware of how to report concerns externally, inconsistent infection control practices and individual risk assessments not always being adhered to, this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that there were not always enough staff. One person said, "They could do with more staff, sometimes there just isn't anyone around." Another person said, "Are there ever enough staff for people? But no there are often not enough staff for people in their rooms and people outside sitting around." All staff we spoke with told us whilst people's needs were met there were not enough permanent staff employed to provide cover. For example one day prior to this inspection there were five permanent staff on duty and six agency staff members with a unit manager working on the floor to support the staff to meet people's needs. A person told us, "The trouble is that the staff come and go, some do short shifts, some do just a few days – you never know where you are." A relative said, "There's no continuity and no consistency with staffing and that means communication is non-existent."

Staff told us that shifts were covered most of the time but there were frequently a couple of hours in the

morning, while they were waiting for staff cover to arrive and they worked short. Staff told us that they had been told by management that on these days, people who needed two staff to support had to wait in bed until after breakfast. One staff member told us that they always checked these people were clean and comfortable and were able to wait until later in the morning. However, staff also told us that during the hours where they were short, the registered manager and deputy manager stayed in the office and did not support people or the team. One staff member told us that at times the deputy manager would go to the units and dispense medicines to help.

The registered manager, with support from the regional manager, confirmed that they had staff vacancies of 307 hours per week which was equivalent to just over eight fulltime staff members. Currently these shortages were being covered by staff taking on overtime and agency staff. The regional manager confirmed that there were recruitment initiatives underway to help address this shortfall. Although during the visit we did not see people waiting for long periods of time and call bells were answered promptly, staffing was an area that required improvement.

We noted that people who had been assessed as requiring bedrails on their beds to prevent them from falling had protective covers over the rails to reduce the risk of entrapment.

Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and we saw that records were maintained to confirm when people had been assisted to reposition. We also saw that call bells or mats to alert staff to a person at risk of falling were in place appropriately.

People had personal evacuation plans in place for in the event of a fire and we saw that regular safety checks were completed. We saw records of fire drills which included during night time hours when staffing would be at its lowest numbers and people would be asleep. This helped to ensure that staff were aware of what to do in the event of a fire.

We saw records were maintained of 'near misses' where people had experienced slips, trips or falls but had not sustained an injury. The information recorded included the time of day, the location of the incident and any other relevant factor which enabled the registered manager to identify any themes, patterns or trends.

When we inspected the service on 31 January 2017, we found that medicines were not managed safely. At this inspection, although we found improvements had been made, we noted that there was still further development needed to ensure consistent safe management.

We checked a random sample of ten boxed medicines and found that stocks agreed with the records maintained. Handwritten entries were countersigned and there was a daily checking system by a member of the management team.

We checked the records for one person in receipt of covert medicines which was approved by the GP and pharmacy. However, this did not detail how the medicines were to be given. We noted that staff members were administering capsules covertly by emptying the capsules into yoghurt. The capsules were designed as slow release; therefore, this method of administration could affect the way the medicine was absorbed. A staff member told us they had questioned this with management but had been told the pharmacy had approved it so it had to be done. The management team told us that there had been no consideration to get this medicine prescribed in liquid form. In addition, there had been no care plan developed to inform staff how the person's medicine should be administered, this information was passed from staff member to staff member by word of mouth. This was an area identified at the previous inspection and an area that required improvement.

People were supported by staff who had been through a set recruitment process. We saw that files included information about criminal record checks, references and proof of identity. However, we noted that in one of the files we viewed, gaps in previous employment were not explored, even though this was a question stated on the interview record sheet.

Requires Improvement

Is the service effective?

Our findings

People did not always receive prompt professional involvement. Some people told us that they were visited by the GP when needed. One person said, "If I am worried I can just ask and they put me on the (GP visit) list." However, this was a concern when people may not have been able to request a GP visit due to their complex health needs. We were told by staff that two people receiving pain relief with patches often had pain the day the patches were due to be changed. However, staff had not arranged for additional medicines or a consultation with the GP, even though this had been going on in one person's case according to their care review notes, since April 2017. They stated that when the patch was running out, the person experienced pain on repositioning. This person received two hourly repositioning which meant they may have been in pain for up to 12 times a day. A staff member told us that a GP had been arranged to review this in the coming week. We were also told that a person receiving end of life care had experienced considerable pain, a care staff member had requested that the duty manager contact the district nurse to attend. Two hours later the care staff member found that the call had not been made and the person was still waiting for pain relief. We discussed this with the registered manager and deputy manager who told us that they were not aware of this.

Due to the appropriate action not being taken to ensure people had the required medical input, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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). Mental capacity assessments had been undertaken and DoLS applications had been submitted to the local authority for approval.

'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions and, where appropriate, their family members as well.

Staff had an understanding of the principles of the MCA and told us that a lack of capacity did not mean a person could not take part in day to day decisions and they always assumed people had capacity until assessed otherwise. We noted that staff asked people for their consent before supporting them.

People told us they enjoyed the food. One person said, "The food is pretty good, the cook is good and nice too." Tables were nicely laid with cloths and condiments were on the tables to support people to be independent.

We observed the breakfast and lunchtime meals served in a communal dining room and we noted that people were provided with appropriate levels of support to help them eat and drink. We noted that choices

were offered at the mealtime and staff used the picture menus to help people choose. However, people sometimes had to wait until their food had cooled in front of them before staff were able to support them. For example, people sitting with a pasta dish becoming cold for up to 40 minutes and staff did not take it away even though it would have been cold.

One person at risk of poor nutritional intake was sat with a bowl of chicken soup in front of them. A staff member approached the person saying, "We have chicken soup, I am going to help you, it is a nice winter soup isn't it?" They then distracted the person by chatting about the weather and how it was getting windier, the person started to gradually eat their soup with support from the staff member.

The chef told us that they had a list of people assessed as being at risk from poor nutritional intake. They supplied high calorie snacks and smoothies for people. They also told us that all the sauces, custards and mashed potatoes were fortified with powdered milk and cream.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that one person had lost 8.8kg in weight since January 2017. Their care plan stated, "Staff to encourage [person] to have a good food and fluid intake daily." Another care plan entry stated, "Staff to support [person] a lot more now as they can't manage on their own." However, there was no explanation about how to support the person or suggestions of how staff could encourage the person to improve their dietary intake. When we spoke with permanent staff members they were able to clearly describe different approaches they used to tempt the person to eat. However, the lack of recording meant that agency staff or newly recruited members would not have access to the information they needed to provide the person with effective support. An agency staff member said, "It is OK if permanent staff are available to ask advice but it would be better if the information was written down." This was an area that required improvement.

Staff members told us of various training elements that had been undertaken including basic core training such as moving and handling and safeguarding as well as specific training modules such as end of life care and continence awareness. One staff member said, "[Deputy Manager] is good with the training, she is on top of it." Staff told us that they had received an induction on starting at the home, including the care certificate booklet.

The management team and staff confirmed that there was a programme of staff supervision in place. We received mixed feedback about the frequency and quality of staff supervisions with some staff telling us they barely received any. However, when we reviewed records we noted that these staff members had signed a record of their staff supervision to confirm that it was an accurate reflection of topics discussed.

Most of the staff members we spoke with said they were not fully confident to approach the management team for additional support at any time. They said that the registered manager did not have a visible presence in the home and that the deputy manager was not always approachable. It was reported that some care team managers appeared to listen to the staff team but then did not always carry out agreed actions. However, other staff told us that the care team manager they worked with was very supportive and approachable.

Requires Improvement

Is the service caring?

Our findings

Staff did not always take action to promote people's dignity and self-respect. For example, we noted one person had significant facial hair. A staff member told us that they had identified this but were waiting for the person's key worker to talk to the person's relative to check that they could remove it. However, we spoke with the person's relative and they told us, "Look at this (facial hair) is this ok? I don't think it is acceptable, she was always so neat and tidy." They told us no-one had approached them about removing it.

Staff did not always notice when people needed something. We saw a person was noted to be in pain and clearly distressed. The person had a special cushion for them to sit on to help mediate the pain they experienced but despite them calling out and clearly demonstrating they were in pain they had not been provided with their cushion to sit on. We also saw a person sitting on a specialist chair with their legs dangling. Their care plan stated that with this chair they must have leg support to ensure they were comfortable. A footstool was provided later in the day.

We asked a staff member if they would recommend Providence Court to family or friends. They responded, "There are some really good care staff here, really good, but I wouldn't want my relatives here."

People were not involved in planning or reviewing their care. One person said, "They don't talk to me about my care plan and they never have done." Relatives also told us they were not always involved. One relative said, "We haven't been involved in care plans I think we should from now on." We asked the registered manager and deputy manager about this as we were unable to find any record of involvement, other than relatives signing consent forms. The regional manager asked them was it happening or was it not recorded. The deputy manager told us, "It doesn't happen."

Some staff knew people well. Others did not have as much knowledge. In addition, there was a high number of agency staff being used and no clear process for ensuring agency staff knew the people they supported. One person told us, "They don't know, they don't know what I like. I just do what I like no one seems to mind anyway." Another person said, "The staff knows us really well, well they know our names, even people I don't really know will know my name." The person went on to say, "No they don't know anything about me, they don't know what I did before but they do know my relative visits because she does." A relative gave examples of care which could be more thoughtful. They said, "We asked if [person] could have a glass of sherry each night and we brought in the bottle, we thought it would nice if they shared it with her friend, that was a month ago and less than two glasses have gone from the bottle." However, we did note that another person who enjoyed a glass of whiskey each night, did indeed have this every night. They went on to say, "[Person] had 12 pairs of underwear and today we came in and there are none in the drawer we discovered (not told by carers) so they have all just disappeared – we don't know if [person] is throwing them away with pads or what is happening but they have just disappeared. What happens if we hadn't noticed?"

Due to the inconsistent caring approach and lack of involvement for people, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that staff were kind. One person said, "They are very good here, they care about us but they are very busy." Another person said, "The carers are very nice, I've never heard a curt word from anyone here." A relative told us, "In general individually they are never impatient or unpleasant to anyone that I have heard." Another relative said, "The staff are very, very sweet. [Person] needed changing and it was evening time and the carer asked did they want to go into their nightclothes or back into fresh day clothes. It was all done very gently and kindly." A response to the provider's annual quality assurance survey stated, "The staff are very caring but not always available." A further response stated, "This is a lovely home, our [relative] is comfortable and the regular care team and unit manager take good care of them."

We observed most staff interacted with people in a warm and caring manner listening to what they had to say and taking action where appropriate. For example, one person had complained of feeling chilly and staff brought them a blanket from the person's room and wrapped them snugly in it. However, we also observed a person say 'Good Morning' to a staff member and the staff member did not respond and instead spoke to their colleague who was pushing the person's wheelchair.
We heard a staff member say in the dining room at lunchtime, "Let's put this on (apron) to save your lovely jumper." We saw staff were wearing cotton aprons whilst they served meals and supported people to eat. These were more pleasant than plastic ones and created a homely environment.

People told us that they were able to make choices about day to day living. Some people told us that that they could get up and go to bed when they wanted to. One person said, "I get up very early, I can go and make a drink and now I can have early breakfast, I just go and help myself." Another person said, "I like to have a walk after supper and then come to my room, that works for me. I can go to bed when I want to." A third person told us, "I like to settle about 11 and that's fine then they pop in and out during the night to just check."

The environment throughout the home was warm and welcoming. People's individual bedrooms were personalised with many items that had been brought in from their home such as cushions and pictures and most communal areas had been redecorated to provide an attractive environment for people to live in.

People's care records were stored in a lockable cupboard in communal areas on each unit in order to maintain the dignity and confidentiality of people who used the service. We noted that on some units the cupboard was locked but not on all units.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that met their needs. Although we saw that most people looked appropriately dressed and as though they had received personal care, some areas were lacking. One person old us, "I have a bath once a week, well sometimes a bit longer, and they just fit me in. I don't have a schedule or a slot they just do it when they can. I love it and I'd like to have a bath more often but I can't." Another person told us, "I have a bath once a week – I expect they are too busy to do it more often but it would be nice." A third person told us about baths, "I have to ask and they work it out in their teams so we have to do it when they can."

Relatives also told us that at times care was lacking. One relative told us of a day when their relative was still in their nightdress late in the day and another relative said, "Look at [person's] finger nails (they were very dirty), we've asked several times, they do it and then it happens again. It's just not nice or dignified." Another relative said, "We've asked about bathing, it happens once a week but not necessarily each week and we have requested more often but that doesn't happen." Relatives also questioned oral hygiene as a person had lost front teeth and staff hadn't noticed. We also noticed that some people's teeth were unclean. We noted that a response to the provider's annual quality assurance survey stated, "The standard of care has fallen below what I would expect." However, there had been no changes made as a result of this.

People's care plans were not always sufficiently detailed to be able to guide staff to provide their individual care needs. For example, one person who lived with dementia had fluctuating English language skills. There was no care plan developed to support communication with this person as their cognitive function declined and communication became more of a challenge. This had the potential for the person to be locked into their own world with no opportunity to communicate their needs to staff. In addition, there was no care plan developed to address personal grooming needs such as unwanted facial hair. We also found that plans did not detail supporting people with covert medicines and dietary needs were not specified. However, at times when care plans did give guidance to staff, such as when a person required a footstool to alleviate pressure and provide comfort or to provide pressure relieving cushions, they were not always followed.

Staff we spoke with were not all knowledgeable about people's preferred routines, likes and dislikes and where they were aware of preferences, this information was not always used to good effect. For example in developing personalised activities to avoid the risks associated with people being under-stimulated and bored. In one person's care plan we noted a hand written entry in July 2017 that stated, "[Person] believes in God and attended Church in recent years." Whilst it was positive to note that this information had been captured and documented there had been record of how the service would meet those needs.

During the course of the inspection we did not see any activities taking place on the units in the home. A staff member told us, "Activities are pretty much non-existent. We are told we have to do activities but with additional duties such as cleaning bedrooms, cleaning fridges, toasters and microwaves we don't have the time." We noted that there was a group activity taking place in a day room but this was only attended by six people. However, when asked by a member of the inspection team if they would like to attend, three additional people participated. We guided people to the room as staff did not.

People told us that there was not much to do. Some people who were able told us that they enjoyed going for a walk round the garden and we saw some people go out into the garden for a walk. One person said, "The gardens are lovely, they worked really hard and it looked really beautiful this summer." However we also noted that one person who was cared for in bed had it noted that they enjoyed walking. We raised this with the management team as although they were assessed as end of life care, this had been the case for almost a year and no provision had been made to get the person into a specialist chair and take them into the garden for a walk. One person said, "I used to play dominoes but I do need some support so I need someone who knows how to play, the carer I used to play with doesn't come anymore. I can't expect them to help me find someone else." Another person said, "I used to go shopping with a carer but she left and so I don't go anymore, I did enjoy that." A third person told us, "It's so boring here nothing to do, I'd like to go down it's better than sitting here." The registered manager told us that there had been a garden party in the summer which was hugely attended and enjoyed and also there was a Halloween party coming up. Posters for this were displayed around the home. They also told us they had been completing a 'pimp my Zimmer' programme where people were decorating their Zimmer frame in a variety of styles. We saw some decorated in large playing cards and bunting, one in union jack decor and another with flowers.

We asked a member of activity staff how they knew what people enjoyed and if activities were tailored to suit people's interests and hobbies. They told us, "I don't know, hopefully it is down somewhere but I don't know." We asked people if staff asked them what they enjoyed. One person told us, "We were asked about activities and I said I would like more physical activities, that would be excellent to have something every week. They ask but then they don't do anything." Relatives also told us that activities were sparse and those that were available they felt were not always appropriate. One relative told us, "[Person] has been to the activity group, we went once or twice and they were throwing a bunny around. We were on the other side of the room and [person] caught our eyes and rolled [their] eyes as much as to say 'what am I doing here'."

A response to the provider's annual quality assurance survey stated, "If attention is given to a regular programme of stimulating activities offering multi-sensory experiences I would be rating the home higher." Further feedback stated, "The home is desperately lacking in stimulating activities."

The inconsistent approach to care provision, undetailed care planning and lack of activities was a breach of Regulation 9 of the Health and Social Care Act (regulated Activities) Regulations 2014.

People and their relatives knew how to make a complaint. One person told us, "I have a keyworker but it never worked, I've complained and now I see her a bit more, not much but a bit more." One relative told us that they did not like to complain through fear of repercussions. Another relative told us that they felt the management were defensive if they raised anything. We viewed complaints records and saw that these were responded to in accordance with the provider's policy. However, we noted that the responses may come across to complainants as harsh and lacking acceptance of the mistake. This was an area that required improvement to ensure that people felt able to raise any concerns.

Requires Improvement

Is the service well-led?

Our findings

The deputy manager had a good amount of knowledge of people living in the home. One staff member described them as 'Google' in relation to people's needs and any changes. However, we received feedback that the registered manager was not visible in the home and did not interact with the people who used the service, their relatives or the staff team. People and relatives did not know who the registered manager was. One person said, "I don't know, I suppose I could find out but I don't know." A relative told us, "I have absolutely no idea."

The registered manager told us that they spent time in the office to allow care team managers time on the floor. They told us that they arranged appointments and shifts. We asked if they spent time on the units and they said, "We had a cup of tea with people on the unit the other week." The registered manager and deputy manager told us that they didn't spend time giving support and guidance on the floor to staff as this was the care team manager's job. When we asked how they ensured they had up to date and accurate information about the home they told us they didn't know. People, relatives and staff told us that there was no oversight by the registered manager and limited oversight by the deputy manager.

Staff told us that the management team approach was variable. We were told that there was a strict hierarchy where care staff reported to unit managers who in turn reported to the deputy manager and the deputy manager to the registered manager. Staff said they did not feel that the registered manager was approachable. One staff member said, "Top heavy management team, removed from care. You don't ever see any manager doing anything with a resident." Another staff member said, "[Registered manager] manages from the office." One staff member told us that when the previous inspection report was received in the home the deputy manager was heard to shout, "So who threw us under the bus then?"

One staff member told us that the registered manager was approachable but they didn't have such a positive relationship with the deputy manager. Most staff told us that they went to the care team managers with any concerns. However, as a result, the registered manager was not aware of any issues found in the home on the day of inspection.

Staff said they did not feel supported to raise any concerns or to question any practice or decisions. One staff member said, "You just keep quiet because there is no point." Another staff member said, "I went to them once but was made to feel they didn't have time for it."

Staff told us they did not receive feedback about complaints or incidents occurring at the home. One staff member said, "We don't hear anything about lessons learnt, just have orders shouted at us." All staff told us that communication in the home was poor. The registered manager told us that this information was shared and handovers and team meetings. We noted that team meeting notes did not include much information about remedial actions for lessons learned.

People and relatives also told us that communication in the home was poor. They told us that there was a keyworker system but this was not effective. One relative said, "The keyworker idea is very good, but it's not

implemented so it's not helpful." The registered manager told us that they had been holding meetings to improve communication. We saw that there were notes of one meeting held since the last inspection. None of the relatives we spoke with had been to a meeting. The registered manager told us that they had introduced Sunday lunches and afternoon teas for families. However, no one we spoke with told us about these.

Staff were not empowered to do their roles. One staff member told us, "We are only allowed to talk to families about how their relatives, nothing else."

Following the inspection on 31 January 2017, there was a breach of Regulation. As a result the provider was required to submit an action plan setting out how they would make the required improvements. However, this was never received. We asked the registered manager for this on the day of inspection. They told us it had not been completed.

There were quality assurance systems in place which included audits and surveys. These were undertaken by the home's management team and the provider. The regional team had identified some areas of improvement and there was an action plan but overall, with their systems, they rated the service good at their last audit. However, the issues we found as part of the inspection did not agree with their findings. The registered manager told us that they were shocked with our findings as they were not aware of any of the issues identified. We asked how they were monitoring the quality of the service and they were unable to give us any additional information than we had already viewed.

Satisfaction surveys were distributed annually to people who used the service, their friends and relatives. Feedback from the most recent survey completed in September 2017 included, "Providence Court is a good home but not as friendly and happy as it was six years ago."

Due to the issues found on inspection, and that well led was rated requires improvement as part of the previous inspection, this was a breach of Regulation 17 of the Health and Social care Act (Regulated Activities) Regulations 2014.

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 were not consistently receiving person centred care that took account of their health, care and social needs. In addition, people were not involved in planning or reviewing their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems did not ensure issues found on inspection had been identified and resolved. In addition an action plan had not been provided following the previous inspection.