Embrace Uk Limited

Lake View Nursing Home

Inspection report

Chorley Road
Withnell
Chorley
Lancashire
PR6 8BG
R6 8BG
Tel: 01254 831005
Website: www.europeancare.co.uk

Date of inspection visit: 2nd October 2014
Date of publication: 26/01/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out an unannounced inspection on the 2nd October 2014. We did this to check whether the provider had met the requirement of the breaches in relation to regulations 9, 10, 13, 15, 18, 22 and 20. We found evidence of ongoing concerns and furthers breaches in regulations.

The service did not have a registered manager in post on the day of our inspection. The previous manager left their post in March 2014 and there had been several changes of the management team in the home since March. There was an interim manager in day to day charge of the home who had been in post for 12 weeks. 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 and associated Regulations about how the service is run.

Summary of findings

Lake View Nursing Home is registered to provide care for up to 51 people. At the time of our inspection there were 31 people living in the home. The home was providing nursing and personal care for people, including those living with a dementia.

Prior to this inspection we had previously visited the home on 12th and 13th March 2014 and identified breaches of regulations 9, 10, 13, 15, 22 and 20. We asked the provider to send us an action plan in relation to regulations 9, 13, 22 and 20 to tell us how and when they would ensure they met their regulatory requirements. We issued the provider with a warning notice for regulations 10 and 15 and told the provider by what date they needed to meet their regulatory requirements.

We revisited the home on 6th June 2014 to check whether the provider had met the requirements of the warning notice. However we identified ongoing concerns with regulations 10 and 15 and identified further concerns in relation to regulation 18.

During this inspection we found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection we found there were some improvements in relation to regulation 9; for example we spoke with people who used the service and their family about the care they received in the home. We received some positive feedback about the care provided by staff employed by the provider. However people were not as confident about the use of agency staff providing care for them.

There was a lack of provision for people in relation to their personal care needs in the home. For example there was no provision for people to have access to a bath on one of the floors due to the ongoing refurbishment work and one person told us they had not had a bath for some time.

We saw copies of notifications that had been sent to CQC in relation to allegations of abuse but could see no evidence of the investigation that had taken place. We were made aware of a concern raised by a relative of one person in the home. We discussed these concerns with the regional manager during a feedback session who told us they had not been made aware of these concerns and confirmed they would investigate them.

During our inspection we found some improvements had been made in relation to the administration of medicines. We found medicine administration records (MAR) documented when a medicine was given and we saw completed records detailed the reason why a medication had not been given. Medicines were stored in a lockable trolley. However we saw the medication trolley had been left unattended on two occasions during our inspection and we noted one occasion a medication liquid was left on top of the trolley and we saw evidence that the recording of the fridge temperature identified abnormal readings that had not been reported to the interim manager. This meant the provider did not protect people who used the service against the risk associated with the unsafe use and management of medicines. You can see what action we told the provider to take at the back of the full version of the report.

During our inspection on we looked at how people who used the service were supported with their nutritional needs in the home. Staff were seen engaging well with people who used the service; we noted positive eye contact and communication as well as staff assisting people with their dietary needs. Staff were observed offering a choice of meals including alternatives to the menu. However we noted some concerns; these included a lack of consistency when staff completed nutritional monitoring records We also observed inaccurate recording of the intake of food and fluids for one person who used the service. We spoke with the interim manager about this who commenced an investigation. People told us the meals were poor when the chef was not in.

During our inspection we found there were some improvements to the premises including the refurbishment and redecoration of some areas of the home. However we observed there were significant health and safety risks which had not been appropriately managed during this process of refurbishment. We noted there was also a lack of pictorial signage to aid people with orientation in the home.

During our inspection we could not see evidence that people living in the home or their family had been consistently involved in decisions relating to their care. However a relative of one person we spoke with confirmed they had discussed the care of their relative with the staff. There was a breach of regulation 17of the

Summary of findings

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not have suitable arrangements to ensure people who used the service were enabled to make, or participate in in making decisions relating to their care or treatment.

We looked at how the provider dealt with notifications to the Care Quality Commission (CQC). We noted there was some evidence of notification being sent to us in relation to serious injuries, allegations of abuse and deaths, as required by law. However we found the manager had failed to notify CQC of to two authorisations under the Deprivation of Liberty Safeguards and three falls which resulted in people being admitted to hospital.

We looked at how the provider dealt with complaints. We saw there was a complaints file in place. There was evidence of the complaints received by the provider and actions that had been taken to resolve these. We discussed a complaint that we had been made aware of with the manager and regional manager. They told us they had been made aware of the complaint and taken actions relating to this but the details had not been recorded. We were told complaints were discussed at staff meetings; however we noted in records relating to a recent staff meeting that the topic of complaints was not documented. Staff had access to a copy of the complaints policy for them to follow and staff we spoke with told us were they were aware of the policy; however we noted the date for review of this policy was four months prior to our visit.

We looked at how the provider monitored the quality of service provision and saw some evidence of checks and audits taking place, however there were some concerns that these audits were not always being fully completed and one audit had last been completed in 2013.

During our inspection we looked at the care files for six people who used the service; these were kept securely in the home. We saw each person had an individual care file in place; however they lacked accuracy, consistency in their chronology, were brief and difficult to navigate. We saw reviews of care plans were taking place however we noted there were inconsistencies in the documentation relating to their completion. For example we saw a monthly support plan evaluation form that had been commenced recently but it not been completed in full.

During our inspection we looked at staffing numbers in the home. We were told recruitment was ongoing in the home and staff we spoke with confirmed appropriate recruitment systems when they joined the service.

We found ongoing concerns regarding the number of staff available to meet people's needs, for example we saw evidence of cover for catering duties noted on some days; however on other days we noted gaps in the duty rota where no staff member had been allocated to cover catering duties. People who used the service were at risk of inadequate provision to provide their meals because there was no evidence of allocated staff to cover catering duties.

There was very little evidence of meaningful activities taking place in the home and records relating to activities had not been completed for some time. Staff told us they didn't have time for activities. Relative and people who used the service we spoke with told us activities were lacking in the home and there was also a lack of staff.

A dependency assessment tool was used to identify approximate numbers of staff were in place to care for people's individual needs; however we noted this did not take account of people who were receiving one to one supervision and the tool had not been completed for three weeks. Staffing rotas were difficult to follow and it was difficult to identify staffing cover. Details relating to the training and details for agency staff was in place however, we could find evidence of checks on some of the staff who were identified on the staffing rota.

Summary of findings

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.

We saw evidence of some improvement in the home however we noted there was still ongoing concerns in relation to the homes refurbishment, safe storage arrangements and lack of measures to ensure people who used the service were cared for in a safe environment.

During this inspection we found some improvements had been made in relation to the safe administration of medicines however ongoing concerns were identified. We saw medicine administration records (MAR) documented when a medicine was given and we saw completed records that detailed the reason why a medication had not been given. However we observed the medication trolley was left unattended in the corridor on two occasions and we observed on one of these occasions there was a medication left on the top of it.

We looked at staffing numbers in the home and we were told the home had a fully recruited nursing staff team and were still in the process of recruitment for two caring staff members. We saw gaps in cover for catering duties. People who used the service were at risk of inadequate provision to provide their meals because there was no evidence of allocated staff to cover catering duties.

Staff told us they were aware of the safeguarding and whistleblowing (reporting bad practice) policies and where they could access these. Staff told us they would report any concerns to the manager. However we were made aware of a concern raised by a relative of one person in the home. We discussed these concerns with the regional manager during a feedback session who told us they had not been made aware of these concerns and confirmed they would investigate them.

Is the service effective?

Inadequate

The service was not effective.

Three people were subject to a Deprivation of Liberty Safeguard (DoLS). Two DoLS had been authorised by the Local Authority but the provider had failed to inform the Care Quality Commission (CQC), in line with their regulatory duty. One staff member told us they had received no training in MCA and DoLS for 8 years but they kept themselves up to date. Another said they had not received training but they were able to demonstrate an understanding of MCA.

We looked at the training matrix and saw details relating to percentages of the staff that had completed training in the home. The interim manager told us training was on going and there were plans for all staff to be up to date with training in the home.

During our inspection we observed the lunchtime period in both dining areas of the home. Staff were seen engaging well with people who used the service; we noted positive eye contact and communication as well as staff assisting people with their dietary needs. Food

Summary of findings

and fluid charts we looked at lacked consistency and accuracy of recording. This was because staff had recorded details relating to food and fluids intake as taken for one person who used the service. However we observed their drinks and meal had been taken away by staff untouched.

Is the service caring?

Inadequate

The service was not caring.

We received mixed feedback from people who used the service about the care they received in the home. We noted staff appeared to be caring when supporting people who used the service. The lounge was observed to be supervised by staff during the day of our inspection.

The atmosphere in one of the lounges was unsettled in the later part of the day and people who used the service appeared to be in some levels of distress, shouting and vocalising at times. Staff were seen assisting people, offering some reassurance to some of the people sat in the lounge. However on one occasion we observed they offered little reassurance when assisting and supporting one person who used the service.

Care records had limited information about whether or not people who used the service or their relative had been involved in making decisions and choices about their care. However in one file we saw evidence of comprehensive details relating to a person's end of life wishes.

Is the service responsive?

Inadequate

The service was not responsive.

People told us there were few activities available for them to take part in. Records we looked at that related to activities had not been completed for some time. Staff we spoke with told us they were very busy and had little time for activities.

We looked at how the provider dealt with complaints. We saw there was a complaints file in place. Some complaints received by the provider were recorded; however we had been made aware of a complaint raised in the home which was not documented. We were told actions had been taken in response to the complaint.

Information in care files to guide staff on people's individual needs were brief and contained limited details relating to their care needs or their wishes and preferences.

Is the service well-led?

Inadequate

The service was not well led.

We looked at how incidents and accident were recorded. We saw evident of accident reporting taking place however these were not detailed and the provider had not informed the Care Quality Commission of three accidents that had resulted in a hospital admission.

There was an interim manage in post who told us they would commence the process of applying to register with CQC; however following our inspection we could not find any evidence that they had started this process. We received some positive feedback about the interim manager.

We saw evidence of some positive feedback from relatives of people who used the service in a recent questionnaire.

Summary of findings

We asked the manager to show us how they monitored the quality of service provision. We noted some improvements had been made since our last inspection; however we still had concerns on this inspection regarding the effectiveness of some quality assurance processes.

Lake View Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 2nd October 2014 and was an unannounced inspection which meant the provider and staff did not know we were coming.

The inspection was carried out by a lead inspector and three additional inspectors. The inspection team also included a specialist advisor for people living with a dementia 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 had experience of care homes which provided nursing and dementia care.

Prior to our inspection we reviewed the information we held about the service. This included notifications, safeguarding concerns and information detailed in action plans that the provider had sent to us following our last inspection.

During our inspection we spoke with 10 staff members; these included care staff, administration staff, maintenance staff, the chef, the regional manager, and the interim manager. We also spoke with an agency nurse who was on duty in the home on the day of our inspection.

During our inspection we spoke with 14 people who used the service, six visiting family members and one visiting professional. We also spoke with a visiting workman who was carrying out refurbishment work in the home on the day of our inspection as well as the company director who was responsible for the refurbishment work being undertaken.

We spent some time observing care and staff interactions with people who used the service in the communal areas of the home and we undertook a Short Observation Framework for Inspection (SOFI) observation. SOFI is a tool to help us assess the care of people who are unable to tell us verbally about the care they received. We looked at the care records for six people who used the service and other documents which included medication administration sheets, policies, safeguarding file, accident reporting, audits and documents relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our inspection on 12th and 13th March 2014 we identified a breach of regulation 13. Of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people were not adequately protected against the risks associated with medicines because appropriate arrangements were not place in relation to the safe administration and recording. We asked the provider to send us an action plan. We revisited the service on 2nd October 2014 to check whether the provider had met the breach of this regulation.

At our inspection on 12th and 13th March 2014 we found evidence of a breach of regulation 22. This was because the provider was unable to demonstrate there were sufficient numbers of care staff to meet people's needs at all times. We asked the provider to send us an action plan. We revisited the service on 2nd October 2014 to check whether the provider had met the breach of the regulation.

During this inspection we found some improvements had been made in relation to the administration of medicines, however we identified ongoing concerns. We looked at the medicine administration records for 16 people living in the home. Medicine administration records (MAR) documented when a medicine was given and we saw completed records that detailed the reason why a medication had not been given. This meant medicine records were up to date and accurate, which is important for healthcare professionals when they are determining the continuing healthcare needs of people.

People's care plans recorded information relating to medicines. For example, we found appropriate procedures were available for medicines prescribed 'when required' such as painkillers or medication for anxiety or agitation. Staff were also able to tell us when they would give these medicines. This information was important to help inform healthcare professionals about ongoing healthcare needs for people. This meant people received their medicines when they needed it.

We looked at how medications were administered in the home and saw there were systems in place to make sure medication was administered safely and as prescribed. Only trained members of staff were given the responsibility for the administration and recording of medication, recording and administration of medication, including controlled drugs. A check of the controlled drugs in stock corresponded accurately with the records.

We looked at the storage of medicines in two medicine trolleys and in one clinical room. We noted the trolleys were secured in the clinic room when not in use and medicines were stored neatly in two medicine trolleys, which made it easy to locate people's medicines. However on two occasions during our inspection we observed the medication trolley left unattended in the hallway during the medication round. On one of these occasions we noted there was unattended medication left on the top of the trolley that had been prescribed for one person who used the service. We brought this to the attention of the interim manager immediately on both occasions, who in turn asked the nurse responsible to return to the trolley. We could not be confident people using the service were safe because effective systems for the safe storage of medication were not in place.

We looked in one of the clinic rooms and noted there was documentation related to recording the temperature of the fridge and the room. We noted some of the records detailed temperatures outside of the range recommended by the manufacturer for the safe storage of the medicines in use. For example, one of the documents related to a recent weeks recording of the fridge temperatures detailed nine episodes where the temperature had exceeded the guidance on the document. We saw only four of these entries detailed that the staff had reset the fridge. In addition there was no evidence to demonstrate the temperature reading had been checked following this, or if any of the abnormal ranges had been reported to the interim manager. We also noted recent record relating to the temperature of the room where medications were stored. During a one month period we noted on ten occasions the temperature had exceeded the guidance on the record. We saw the guidance on the recording form directed staff to inform the manager if the temperature exceeded 25C. We asked the interim manager and the regional manager about these recordings who told us they had not been made aware of the abnormal readings. Medication should be stored according to national guidance and manufacturers guidelines. We could not be

Is the service safe?

confident people who used the service were cared for safely and effectively because effective systems were not in place to monitor and report abnormal temperature ranges for the storage of medications.

We discussed what system the provider had in place for monitoring and auditing medications. The interim manager told us audits took place for medications monthly and we were shown copies of the audit. This detailed areas looked at including MAR charts checklists, medication ordering and stock. One of the audits we looked had not been fully completed or signed. This meant we could not be confident about the accuracy of this audit.

There was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not protect people who used the service against the risk associated with the unsafe use and management of medicines.

We looked at how the provider managed staffing and recruitment. We were told the provider had a fully recruited registered nursing staff team that had been registered with a professional body and were still in the process of recruitment for two care staff members. One staff member we spoke with told us about appropriate systems of recruitment including disclosure barring checks (DBS) and references. Three staff files we looked at had evidence of the recruitment process in place.

We were shown the duty rotas for the provider and saw evidence of staffing numbers in place, however it was very difficult to establish which staff were currently employed by the provider and who were agency staff members as some entries only detailed people's first names. We also found the duty rotas were very difficult to follow as there were a number of entries that had been crossed out and we could not see what had been recorded underneath.

The interim manager showed us the agency induction file which held details of the skills, experience and qualifications of agency staff members who worked in the home. We noted three of the staff members who were recorded on the duty rota for shifts in the home had no details relating to them recorded in this file. We could not be confident effective systems were in place to ensure people who used the service were cared for by staff who were suitably qualified and experienced to meet their needs.

We asked the regional manager how they ensured there were sufficient numbers of staff in place to care for people safely and effectively. The interim manager told us a dependency assessment tool was completed weekly to ensure there were sufficient numbers of staff in place in the home. We looked at the records relating to this and noted it had not been completed for three weeks. Records seen did not include the needs of people who used the service who required one to one supervision by staff. We discussed this with the interim manager who told us the one to one supervision of people who used the service was usually completed by agency staff, but was unable to tell us why people who required one to one supervision from staff were not included in the assessment. A staff member we spoke with told us, 'Staffing levels were set following dependency levels being obtained by the management'. The inconsistency in information we received meant we could not be confident effective systems were in place to regularly assess and record if there were enough staff were in place to care for people's needs.

We spoke with people who used the service and visiting relatives about the staffing numbers in the home. We were told, "The staff are always busy, they have a lot to do", "The staff never have time to sit and talk to you. People tend to stay in their rooms, it's quite solitary", "If I need anything they (the staff) come", and, "I feel staffing upstairs is worse. There are not enough staff to feed people upstairs. The agency staff are not helping the regular carers. In some instances there has been only one regular carer and the rest have been agency carers and the nurse." One relative told us they had been told by the manager the staffing levels match the amount of money coming in to the home from fees.

Staff we spoke with on the day of our inspection told us, "There are not enough of us. Lots of people have left since I've been here and they are not replaced", "There is no time to spend with people but everything gets done. There are too many agency staff although some come regularly and are brilliant, "No there is not enough" and, "They say we have enough but we are using that many agency staff who don't know people (people who use the service) everything takes longer."

We discussed the concerns raised about the staffing numbers with the interim manager and the regional manager who told us the staff had not raised any concerns with them about the staffing levels. However we noted in

Inadequate

Is the service safe?

the minutes from a team meeting that had taken place recently reference was made to staff discussing the home was short staffed. People who used the service were at risk of unsafe care because there was a lack of a regular and supportive staff team in place.

We looked at what arrangements were in place for ensuring people who used the service received meals prepared by appropriately trained staff member. We saw evidence of cover for catering duties noted on some days; however we noted gaps in the duty rota where no staff member had been allocated to cover catering duties. This meant we could not be confident effective arrangements were in place to ensure people who used the service received meals from a suitably trained member of staff.

There was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced people employed.

We looked at how the service managed risk. We looked at risk assessment in the care files for six people who used the service. There was some evidence of risk assessments in place. However we saw in one care file a clear assessment, which identified how risks were to be managed, was not in place. For example, we saw insufficient guidance on how staff were to protect a person from the risk of dehydration by promoting sufficient fluid intake.

We spoke with some of the staff about their understanding of the safeguarding procedure and what actions they would take if they suspected abuse had taken place. These procedures are designed to protect vulnerable adults from abuse and the risk of abuse. Staff told us they were aware of the safeguarding and whistleblowing (reporting poor practice) policies and where they could access these. Staff told us they would report any concerns to the manager. One staff member told us they felt people who used the service were safe in the home. One person who used the service told us they felt safe and a visiting family member had no concerns about the provider.

We were shown a training record by the interim manager which detailed 78% of staff in the home had completed training in the protection of vulnerable adults. The interim manager told us training was ongoing in the home. This provided evidence that staff in the home had completed training to enable them to identify the signs of abuse.

We looked at the notifications the provider is required by law to make to the Care Quality Commission. Copies of these were filed in the home. We found there was no detail recorded about actions and investigations undertaken by the provider in relation to allegations of abuse.

Following our inspection we were made aware of some concerns reported by a relative to the staff in the home. We discussed these concerns with the regional manager during feedback after our inspection. She told us they had not been made aware of these and confirmed they would investigate them. We could not be confident the system for reporting allegations of abuse was effective.

There was a breach of regulation 11. (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because systems to ensure that people who used the service were safeguarded against the risks of abuse because they responded appropriately to any allegations of abuse were not in place.

Inadequate

Is the service effective?

Our findings

At our inspection on 12th and 13th March 2014 we found evidence of a breach of regulation 15. This was because people who used the service, staff and visitors were not protected against the risks of unsafe premises. We asked the provider to send us an action plan. We revisited the service on 6th June 2014 and found evidence of an ongoing breach of regulation 15. This was because people who used the service, staff and visitors were not protected against the risks of unsafe premises. We revisited the service on 2nd October 2014 to check whether the provider had met the breach of the regulation.

At our inspection on 6th June 2014 we found evidence of a breach of regulation 18. (2) (b) (ii) This was because the Care Quality Commission was not being informed of notifiable incidents and accidents in the home. We revisited the service on 2nd October 2014 to check whether the provider had met the breach of this regulation.

We looked around the outside areas of the home and saw improvements; for example new gutter downpipes were evident, the drains were clear, the environment was cleaner, fencing had been erected around an area of the gardens and new decking was in place. We noted this area was accessible from the outside through an unlocked gate and we were able to access the inside of the home via a door. The interim manager told us this door should be secure. We could not be confident people who used the service were protected from the risk associated with unsecure access to the home.

We undertook a tour of the communal areas and some of the bedrooms in the home. We noted there had been some improvements; for example some bedrooms had new sinks, there was evidence of redecoration taking place in some of the bedrooms, some of the bathrooms were being refurbished and the installation of new fires doors was taking place. However we noted ongoing concerns in relation to the environment.

On the upstairs unit, we noted there was a lack of pictorial signage to aid orientation and a lack of stimulation on the unit for people who used the service. At the start of our inspection we noted the white board on the unit, used to help orientate people had the date incorrectly recorded as September; however was changed during our inspection to display the correct date.

We asked family and visiting professionals about the ongoing refurbishment work taking place. A relative of one person told us, “The outside has been improved, but it is not used. The dining room upstairs has been repainted, but the blinds are broken and the curtains do not close”. A visiting professional told us, “I am amazed at the explosion of renovation work in so many areas and feel that the disruption is affecting residents (people who used the service). It is a difficult balance because, while it will improve the look of the place, personal care is more important.”

During our inspection we noted there were a number of pieces of unattended equipment used for the refurbishment work left out in the corridor of the home as well as in open rooms. Examples seen were a battery operated drill, hand saw, tool boxes, sealant, a rubbish bin with wood shavings, an electrical saw, electric extensions and workbenches. We brought this to the attention of the interim manager who asked the workmen to leave the building. This meant people who used the service were at risk because effective system to ensure equipment was stored safely was not in place.

We spoke with the interim manager about our concerns in relation to the lack of monitoring of the equipment brought into the home by the contractors. We were told the interim manager ‘took their focus off the contractors on site on the day and that once she was made aware of the concerns immediate action was taken and the incident was reported to the contracts manager’. We spoke with the contracts manager who visited the home on the day of our inspection. They informed us all of their staff were expected to store their equipment safely at all times and there was a health and safety file available in the home for contractors to refer to if necessary.

We looked in three of the bathrooms upstairs and one bathroom downstairs. We noted one was filled with equipment including a cleaning trolley, a mirror on the floor, small mantel clock, dirty linen and a small piece of activity equipment. We could not be confident this bathroom was able to be accessed safely by people who used the service. Another bathroom upstairs was also noted to be unlocked. There were wires left on the floor of the room, uncapped, exposed pipes, rubbish and debris left on the windowsill.

A third bathroom which was seen to be a ‘wet room’ also contained items of equipment in it such as a commode.

Inadequate

Is the service effective?

Staff told us this was the working bathroom and had been used on the day or our inspection. However we noted the door to this room did not close properly and a gap was evident between the door and the door frame. We discussed this with the interim manager and the deputy manager who told us they had not been made aware of the problems with the door. People who used the service were at risk because systems to monitor the suitability and safe use of the building were not in place.

We found evidence there was a risk to people who used the service and staff because areas undergoing refurbishments were not secured to protect them. A staff member told us one of the rooms we looked at upstairs was being converted into a new treatment room. We noted this room was in the process of refurbishment and was unlocked and unsafe. Inside this room, we saw exposed pipes, a lunchbox on the window sill which contained unlabelled food, there were two unsecured electric sockets with exposed electric wires, and on the counter top and inside the drawers there were several screws and wall fixings.

We noted some of the bedrooms had notices on them identifying them as temporary storage rooms, and although they were identified as locked, not all of them had been.

We spoke with one of the agency staff members who told us they had not been made aware of the ongoing building works and the associated risks when they started their shift at the home. This meant staff were not aware of the procedure to take and the associated risks in relation to the ongoing work at the home.

The system to ensure any required maintenance work in the home was recorded and carried out was ineffective. Staff told us there was a maintenance book in place for them to record required maintenance tasks. However we were told this book had been 'thrown away' prior to our inspection and had not been replaced. We were told any jobs were handed over verbally at present and nothing was being documented as completed. We discussed this with the interim manager and the regional manager who told us the maintenance book was kept in the reception area of the home or in the treatment room. However they were unable to locate it on the day of our inspection. They told us staff had not made them aware the maintenance book was missing. We noted this was replaced prior to us leaving on the day of our inspection.

We were told regular checks were completed and recorded. These included fire checks, water checks, monthly temperature, wheelchair and bed checks. We were told the checks were signed by the manager and actions were noted. We were shown a file which had details of relevant certificates, for example Portable Appliance Testing, the quality assurance manual and quality policy for the provider. We saw one of the documents related to checks on the boiler, had identified a concern that needed to be repaired. However we could not find evidence the actions detailed had taken place. We discussed this with the interim manager and the regional manager on the day of our inspection who could not confirm the work had been completed however we received confirmation from them in relation to this following our inspection. It is important to ensure records relating to checks on equipment in the home contain relevant and up to date evidence that the home is safe and for people to live in.

There was a breach of regulation 15. (1) (c) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not ensure people who used the service were protected against the risks associated with unsafe or unsuitable premises.

We looked at the record which documented the training completed by staff in the home. We saw 64% of staff had completed training in basic life support, 70% in equality and diversity, 88% in dementia, 80% in first aid, and 75% in infection control. The interim manager told us training was on going and there were plans for all staff to be up to date with training in the home. We were also shown individual records that detailed what training had been completed for example; communication, medications, conflict resolution and moving and handling. Records indicated when these had been completed or when they we due for renewal.

We asked staff about the training they had received in the home. We were told, "Most of the training is completed in the home via e-learning." Staff confirmed they had completed mandatory training relevant to their role. One staff member told us they had completed an induction when they commenced working in the home that involved two days of mandatory training but had not been able to complete the e-learning due to problems with 'logging in' to the computer. They confirmed they had been allocated a mentor to support them. Another said their induction consisted of being 'shown around the home and training via e-learning.'

Inadequate

Is the service effective?

We asked staff about what training they had completed to enable them to care for people living with a dementia. Two of the staff told us they had received training in dementia however one staff member said, "People (people who used the service) upstairs are more challenging and I have not had the training to deal with this." Three other staff members we spoke with told us they had received no training on dementia or challenging behaviour. This meant we could not be confident effective systems were in place to ensure staff had the knowledge and skills to care for people who used the service living with a dementia. There was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not ensure that at all times there were sufficient numbers of suitably qualified and skilled people employed.

We asked the interim manager about how staff attitude and behaviours were monitored. We were told this was "By being on the floor and staff supervision is now in place and being approachable for staff".

We looked at the staff files for three currently employed staff members. We saw evidence of supervision that had taken place in two staff files in January 2012 and March 2014. We were also shown a separate supervision file by the interim manager. This contained details of recently completed supervision for some staff members. We saw a system was in place to record planned dates for staff supervision in the home.

We looked at how people were supported with eating and drinking. During our inspection we observed the lunchtime period in both dining areas of the home. We observed tables were nicely set and had details of the menu on offer for the day on some of the tables. However in one of the lounges we observed the dessert was different to what was detailed in the menu. The interim manager told us there was a rotating menu for people who used the service and alternative would be offered if required. We observed a visiting family member had been invited to eat a meal with their relative. We were told they enjoyed their meal. Staff were seen engaging well with people who used the service; we noted positive eye contact and communication as well as assisting people with their dietary needs. Staff were observed offering a choice of meals including alternatives to the menu. We saw evidence of a food and meal time audit that had been completed in the home.

People using the service told us the, 'food was good though not outstanding and there were suitable choices available'. One person we spoke with told us they found it difficult to reach their drinks and could not reach the call bell in their room; we noted this was positioned behind the person's bed therefore they were unable to reach it. This meant that they would not be able to summon assistance with their nutritional or other care needs.

We spoke with visiting relatives about food and drink available to people in the home. We were told they had some concerns in relation to the meals on offer. One person told us, "The meals are poor when the chef is not in. There is no consistency with the food." Another family member told us they were visiting the home two to three time per day as they were 'worried' their relative was not getting drinks. They told us of occasions when no drinks were offered in the afternoons to their relative. This meant we could not be confident people who used the service received adequate fluid intake in the home.

Food and fluid charts we looked at lacked consistency and accuracy of recording which meant people who used the service were at risk of unsafe or ineffective care. This was because we observed one person who used the service was offered a drink by staff. We saw this drink was removed by staff untouched and recorded on the fluid chart as taken. We also observed staff had recorded this person had eaten their lunch time meal; however we observed this was removed from the person's room untouched. We did not see staff offering support to this person with their food and fluid intake. We discussed these concerns with the interim manager who confirmed they would commence an investigation into our concerns immediately and report them to the local authority safeguarding team. Other food and fluid charts we reviewed were incomplete and there were no details on one person's record of what action staff should take if concerns were noted regarding the person's food and fluid intake.

We looked at seven files kept in the upstairs lounge for staff to document food and fluid intake, observation and topical cream administration. One staff member we spoke with about these files told us they had not been completed for the shift up to the time we looked at them. They said, "I haven't done anything in them yet as I am not a miracle

Is the service effective?

worker." This meant we could not be confident people who used the service had accurate and regular monitoring of their dietary needs to ensure they received safe effective care

Care plans we looked at lacked consistency and regular monitoring of the dietary needs of people who used the service. This was because we saw evidence of malnutrition screening in place; however in two people's files records had not been completed for two months. We could not see any evidence of care plan reviews or actions in relation to nutritional needs in these files.

There was a breach of regulation 14. (1) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider failed to ensure the people who used the service were protected from the risks of inadequate nutrition and dehydration.

Staff we spoke with told us there were three people currently living in the home subject to a DoLS. The interim manager told us two of the DoLS had been authorised by the Local Authority some time prior to our inspection. It is a regulatory responsibility for providers to inform the Care Quality Commission (CQC) when a DoLS had been authorised. The CQC had not been made aware of the DoLS authorisations. We discussed this with the regional manager and the interim manager at our inspection who could not confirm why CQC had not received the notifications. The required notifications were sent to CQC following our inspection.

There was a breach of regulation 18 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider failed to notify the Care Quality Commission of a result of a request to a supervisory body of an application to deprive a person of their liberty.

We asked staff about their understanding of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA 2005) sets out actions to be taken to support people to make their own decisions wherever possible. The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests. Whilst some staff spoken with had an understanding of the MCA one lacked understanding. One staff member told us, "People have the right to make their own decisions." Another said the MCA is when, "They can't make decisions for themselves so they need someone to make decisions for them." However another said they had 'not much' understanding of DoLS and had never heard of the MCA.

Two of the staff we spoke with confirmed they had received training in the MCA and DoLS. One person told us they had received no training in MCA and DoLS for eight years but they kept themselves up to date. Another said they had not received training but they were able to demonstrate an understanding of MCA. We could not be confident staff had received the updates required about DoLS and MCA to enable them to care for people who used the service safely and effectively. The regional manager was aware of changes to the law in relation to DoLS.

We looked at documentation relating to the request for authorisation for DoLS in one of the care files we looked at. We saw evidence of relevant records however one of these had no date on them. We could not be confident when this had been completed.

A care record we looked at lacked chronology and information relating to DoLS were located in separate areas of the person's care file. This would make it difficult for staff to access and follow relevant information to the person's care. This meant people who used the service might be at risk because staff did not have access to the information they needed to provide effective care.

During our inspection we were told the first floor unit was where people who were living with a dementia were cared for. We noted access to this unit was via a secure door system. We noted if people required access out of this unit they would need the support of the staff to facilitate this as the doors were locked. Locking systems on doors without the appropriate legal approval to restrict individuals in their best interests could mean that people were prevented from the choice to access all areas of the home. This was a breach of regulation 11(2) (a) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider failed to ensure people using services had the appropriate legal approval to restrict individuals in place.

Inadequate

Is the service caring?

Our findings

At our inspection on 12th and 13th March 2014 we found evidence of a breach of regulation 9. This was because incomplete and inconsistent information about the delivery of care and treatment meant there was a risk people's needs were not being met, and the welfare and safety of individuals could not be ensured. We asked the provider to send us an action plan. We revisited the service on 2nd October 2014 to check whether the provider had met the breach of the regulation.

We spoke with people who used the service about the care they received in the home. We were given some positive comments such as, "It's a good service, you can have anything you want. I can manage my own care. I am quite happy here"; "Staff in the main are kind. They do their best in difficult circumstances", "It's aright they seem to look after me. I like the staff they do a good job" and, "I have been here some time now and going back things were not so good but they have been much better recently."

However we were also told, "They (the management of the home) brought out a dignity in care group. That's a joke, it sounds good. Not when you see people taking their clothes off because there are no staff to help them or watch them. I don't get a bath as often as I would like, it must be a month since I had one certainly at least three weeks, I don't like being dirty. It's very distressing being left soiled. Someone will help when they have time." The name of the dignity champion was on display and a staff member we spoke with told us a dignity champion had been introduced in the home.

We asked staff about how they cared for people who used the service. We were told, "I feel the continuity of the care has improved", "Staff received a hand over at the commencement of the shift" and, "I am aware of the importance of facial expression to determine how people feel, what they want." One person said the staff were not paid for hand over time but always 'goes in early and leaves late in order to get a handover'; another staff member told us there was no process in place for handover and the staff take notes and, 'hand written notes' were provided to a staff member however they had not had time to read a more detailed handover summary.

Staff we spoke with told us there was currently no provision for people who used the service to use a bath on one of the floors as a new bathroom was being installed as part of the refurbishment programme. Staff were unable to confirm how long it had been since there was a working bath upstairs. They also told us, 'baths and showers taken by residents (people who used the service) should be recorded in care plans but they had not been recorded for', "quite a while now". Another staff member expressed concerns around whether the care needs of people who used the service were met and when personal items such as toiletries ran out staff had to use other people's toiletries or use the soap from the pump on the wall. A staff member told us they had 'issues with the laundry', often cupboards were empty. They told us clothes were in the rooms today because CQC were in the home. People who used the service were at risk because systems to ensure they had access to personal, safe effective care and suitable equipment was not in place.

The provider had a system to ensure staff who were undertaking one to one care were rotated at regular intervals. This was to provide staff with regular breaks from this intensive work and ensure their health and safety. However we noted this was not being carried out in practice. This was because we discussed the care of people who received one to one care in the home with some of the staff. We were told the staff should rotate every two hours to cover this care but they were not aware of a set protocol for one to one care provision. We saw details on staff meeting minutes that noted staff should rotate hourly when providing one to one care to people who used the service. During our inspection we noted the same member of staff covered the care of a person receiving one to one care for several hours continuously. Staff we spoke with told us this was because it had 'been hectic' that day. However, staff we spoke with said when staff were 'rostered to cover one to one care this would involve the whole shift with no cover except during break times' and "It's always the agency that do the one to one. I have been told they have been funded to do the one to one." This meant that the staff who were caring for people receiving one to one care did not have the opportunity for staff interaction with a wider range of people or allow for them to have regular breaks from this intensive element of their work.

During our inspection we visited one person who was received one to one care in their room. We saw the room was sparsely decorated and contained the personal items of the staff member who was covering the one to one support for the day. We also observed one person in a

Is the service caring?

public area of the home appeared distressed and required some help and support with their personal care needs. We observed a member of staff could not be located easily to support them. We found support from a member of staff in the office who promptly assisted this person with their personal care needs. People could be at risk because staff were not readily available to provide the care people needed.

We observed the care of people who used the service in the lounge during our inspection. We noted staff to be caring when supporting people who used the service and the lounge occupied by people who used the service and was supervised by a member of staff; this was noted to be the same staff member for four hours during our inspection. We saw on staff meeting minutes the staff had been instructed to rotate hourly when undertaking this task.

We observed the atmosphere in one of the lounges was unsettled in the later part of the day and people who used the service appeared to be in some levels of distress, shouting and vocalising at times. One person who was visiting their relative told us they found the lounge area, "Uncomfortable for them and their (named relative) to sit in". Staff were observed to assist people, offering some reassurance to some of the people in the lounge. However on one occasion we observed they offered little reassurance when assisting and supporting one person who used the service.

Visiting relatives of people who used the service told us, "(Named person) is happy, so are we. He loves it here", "A few weeks ago there was a little bit of a change, it was calmer but it didn't last. This place has slowly but surely gone down the pan". Another relative told us they were happy with the care provided in the home. We observed relatives and visitors were made welcome and able to visit freely, which meant people living in the home were able to maintain their relationships with friends and family members.

We looked at comments received on feedback questionnaire's and noted positive comments such as, 'I am sure the way I feel that there is a great amount of hard work being put in by everybody connected with Lake View' and 'the care staff have been excellent throughout.' Feedback from one person commented, 'people supported (people who used the service) were treated with sensitively, dignity and respect. They (the carers) are good, caring and professional staff.' An agency worker on the day of our inspection told us "The carers are quite good."

There was a breach of regulation 9. (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not take proper steps to ensure that people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

We looked in detail at the care records for six people who used the service. We found there was no system in place to ensure staff had access to information that reflected people's preferences or choices. We noted there was very limited information about whether or not people who used the service or their relative had been involved in making decisions and choices about their care. However in one file we saw evidence of comprehensive details relating to a person's end of life wishes.

We asked staff how they supported people to make decisions. One staff member told us, "I ask other staff who know people; I ask people themselves whether they want to get up, where to eat". Another staff member said, "I always ask people what they need, I show people clothes to allow them to make choices". A relative we spoke with told us they had 'briefly gone through the care file recently'; however they felt the record did not fully 'reflect the changes to their relative's condition'. This meant people who used the service were not always involved in decisions about their care.

There was a breach of regulation 17. (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not have suitable arrangements to ensure people who used the service were enabled to make, or participate in, decisions relating to their care or treatment.

Inadequate

Is the service responsive?

Our findings

At our inspection on 12th and 13th March 2014 we found evidence of a breach of regulation 9. This was because incomplete and inconsistent information about the delivery of care and treatment meant that there was a risk that individual needs were not being met, and that the welfare and safety of individuals could not be ensured. We asked the provider to send us an action plan. We revisited the service on 2nd October 2014 to check whether the provider had met the breach of the regulation.

We found there were ineffective systems to ensure people who used the service received meaningful and quality activities; this was because we saw details of activities on one of the unit's notice boards however we saw this was out of date. There were no details of activities in the other unit of the home.

People told us there was very little activities taking place for them. We were told, "There is not much going on really. The staff are always busy", "People tend to stay in their rooms, it's quite solitary, I look forward to my (named relative) coming for a change of conversation." One person told us, "I enjoy walking in the grounds where I can go right around the lake." We saw no activities taking place during our inspection in the home. However on arrival to the home we noted a staff member was outside the home with one person who used the service. A relative visiting on the day of our inspection told us, "There are no activities."

Staff told us the activities coordinator, "Works 20 hours per week but they are on holiday this week and we don't get the time." They told us they wished that the home had more activities and time for people who used the service. Other comments received were, "If I had a wish list for the home it would be more activities and more for them (people who used the service) to do", "Resident (People who used the service) don't have a meaningful day as there is not enough staff", "We try and make time if we're lucky to sit with people. We can have a chat and a laugh"; "We play balloons with people. We will take people on the patio for tea and biscuits" and, "The activity organiser is on holiday for two weeks and there is no plan in place for care staff to follow when she is on holiday." Information we received meant we could not be confident people who used the service had access to meaningful activities in the home.

We asked the interim manager and the regional manager about the provision for activities. They said the provider was looking at local colleges for beauty therapy and that the hairdresser visited the home each week. We were told more individual activities for people who used the service were needed.

We were shown a file that contained details of individual records of activities for people. Records we looked at identified a 'getting to know me tree' which contained topics such as hobbies and interests, likes and dislikes, goals and dreams. However we saw this had not been fully completed in two of the files we reviewed. The interim manager and the regional manager told us record of activities were kept in this file. We looked at the activity log details and noted these had not been completed since May 2014. We could not be confident people who used the service had taken part in meaningful activities in the home.

We saw feedback from relatives in relation to activities all had documented activities were either adequate or poor.

There was a breach of regulation 9. (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not take proper steps to ensure that people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

We spoke with the interim manager and the regional manager about how complaints were dealt with in the home. We were told staff were encouraged to tell the management and that complaints were discussed at team meetings. However we noted in records relating to a recent staff meeting that the topic of complaints was not documented.

One person who used the service we spoke with told us they were aware of the procedure to take if they had any concerns. Staff spoken with told how they would report any complaints they received to the nurse in charge and the interim manager was also available to deal with complaints. We saw staff had access to a copy of the complaints policy for them to follow. However we noted the date for review for this policy was four months prior to our visit. It is important to ensure staff have access to up to date and relevant policies to guide them.

Staff we spoke with told us they we aware of the whistleblowing policies and what actions they would take if

Is the service responsive?

they had any concerns about poor practice in the home. One person said they would 'report to the manager'. The regional manager told us, "We need to encourage and protect staff to bring things forward".

We looked at the care files for six people who used the service; these were kept securely in the home. We saw each person had an individual care file in place however they lacked accuracy, consistency in their chronology, were brief and difficult to navigate. An example seen was that one person's records identified their date of birth; however on checking the records we noted this had been recorded incorrectly. Another care file had records relating to body maps and challenging behaviour filed together meaning it would be difficult for staff to locate relevant information easily; putting people who used the service at risk of unsafe or ineffective care.

Information in care files to guide staff on people's individual needs were brief and contained limited details relating to their care. An example seen was one person's file had details relating to 'keeping them safe'. However we could not see a care plan related to this. People who used the service were at risk because systems to ensure staff had access to records that contained relevant, up to date and comprehensive details about them was lacking.

Four of the six care files we looked at had profile passports which detailed what people's individual needs were. One profile passport had information that would support staff to meet their needs; however we noted some of the profile passports did not provide sufficient details to inform the staff on how people needs were to be met. We saw only four of the six care files contained details relating to a 'this is me' document which recorded people's past occupations and favourite places that could help guide staff on individual's past lives. Ineffective systems to ensure people who used the service were protected from the risks associated with the lack of consistent and relevant documentation were evident.

We saw evidence of some reviews taking place in one file we looked at and there were details for planned dates for reviews seen. Another care file identified a monthly support plan evaluation form that had been commenced recently; however this had not been completed in full. Another support plan that related to the 'my day' form and personal care support plan lacked evidence of updates or evaluation in them. This meant staff did not have access to completed up to date documentation that related to people's needs.

We saw evidence of referrals to relevant healthcare professionals, such as the tissue viability nurse, in order to meet people's skin care needs. Others included podiatry and the GP.

We saw assessments such as body maps were in place; however there was no date recorded on two of the documents in one of the files we looked at. Records that related to one to one monitoring of one person lacked strategies or details as to how staff should deal with any challenging behaviours. However another care file had a behaviour support plan in place which had been signed and agreed by a family member.

Two staff we spoke with told us they did not 'have time to look at care files' on one of the floors. Another staff member said, People have a day to day plan in their rooms." They told us they would refer to the care files if they were not aware of the person's needs. We asked the interim manager and the regional manager about the records relating to people who used the service. We were told, "We need to address the information in care plans. Paperwork has changed since the company changed to Embrace." "Care plans were out of date and did not reflect the current needs." We were told "care plans were not where they needed to be and upstairs will be prioritised." The interim manager told us they planned to "review care plans regularly when the situation settles."

We saw evidence that records were discussed at a recent staff meeting and the improvements that was required. The record stated, 'Care plans still have a way to go but we are getting there, they are going to be condensed, If you feel some of the paper work is not working then tell someone.' 'All paper work needs to be filled in appropriately, it seems that people are struggling with the diet and repositioning charts. If they are not filled in then we will take action, we can't keep telling people over and over again about the same things.'

There was a breach of regulation 9 (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not take proper steps to ensure people who used the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

There was a breach of regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Inadequate

Is the service responsive?

2010. This was because the provider did not ensure people who used the service were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

Inadequate

Is the service well-led?

Our findings

At our inspection on 12th and 13th March 2014 we found evidence of a breach of regulation. This was because the provider did not have sufficient systems in place to regularly assess and monitor the quality of the service people received. We asked the provider to send us an action plan. We revisited the service on 6th June 2014 and found evidence of an ongoing breach of regulation 10. This was because the provider did not have sufficient systems in place to regularly assess and monitor the quality of service provision. We revisited the service on 2nd October 2014 to check whether the provider had met the breach of the regulation.

The service did not have a registered manager in post on the day of our inspection. The previous manager left their post in March 2014 and there had been several changes of the management team in the home since March. There was an interim manager in day to day charge of the home who had been in post for 12 weeks. The interim manager was in post at the home whilst a suitable permanent manager was appointed. The interim manager was supported by the regional manager. The interim manager told us on the day of our inspection they would commence the registration process for applying to register with CQC. However at the time of writing this report no application had been received by CQC. People who used the service were at risk because appropriate arrangements were not in place to ensure they were cared for by an appropriately qualified, registered manager. We are pursuing this matter with the provider.

We were told by the regional manager they had recently recruited to the permanent post of manager but the preferred candidate had not been appointed. However the recruitment process had been recommenced and they told us they were hopeful they would recruit to the position in a timely manner.

We spoke with staff about the management arrangements in the home. Staff told us they enjoyed working in the home and we received some positive comments such as, "(Named interim manager) is fantastic she really tries to get us what we need", "We can talk to (named interim manager). (Named interim managers) door is always open. Since she took over, things started improving. It will take time but it is on the right track." However others told us it, "Feels like you are rushed with everything, a lot of pressure is put on you." They felt this came from senior management above the interim manager. Staff told us they did not feel as 'well led over recent years with the numerous changes in the management; however they could see some signs of improvement.'

We asked staff about the support from the manager. We were told, "Which manager we never have any". An agency worker told us they had not been informed of routines, introduced to staff or shown fire escapes on arrival to the home. We were told they were not introduced to the interim manager until sometime later in their shift. However they commented positively about the support the interim manager gave to them in response to the needs of one person who used the service.

Visiting relatives we spoke with told us they had attended a relatives meeting where they were told a new manager would be in post in September but they had now been told they were not coming. "We want to be reasonable but we are sick of hearing the same things." Another relative told us they felt unable to discuss any concerns with the interim management at the home.

We saw evidence of feedback from a recent questionnaire that had been sent to the relatives of people who used the service. We saw comments such as, 'I do feel the foundation laid by embrace can only get stronger and, 'the care staff have been excellent throughout.'

We noted feedback about specific topics such as, staff, the environment, care and support. We saw some examples of positive feedback around these, however one person had noted the general atmosphere in the home was poor. We saw one feedback questionnaire had been left in a care file for one person who used the service. This contained concerns in relation to the meals provided. We discussed this with the interim manager and the regional manager who told us they had not been made aware of the feedback from staff. This meant systems were not in place to ensure people who used the service or their relatives had their comments reviewed and acted upon.

We saw evidence that staff meetings were taking place. Records included head of department, staff and relative meetings. Topics discussed included staff sickness, recruitment, poor environment, supervisions, and staff training for challenging behaviour. One person said, "They are more regular than they used to be" and, "Can raise issues" in staff meetings. One staff member confirmed a team meeting took place, "Three to four weeks ago". We

Is the service well-led?

saw evidence of minutes from this meeting on the day of our inspection which detailed topics that had been discussed. The interim manager told us people were supported to express their views by them "talking to people, resident meetings plus an open door policy". This meant staff received information and updates from the management team.

During our inspection the interim manager accompanied two of the inspectors on a tour of the building. We asked the interim manager some questions relating to one bedroom for a person in the home. The interim manager was unable to confirm if the room was occupied and had to seek clarity in relation to this person from another staff member. There was an evident lack of knowledge about the people who used the service and which rooms they occupied. A lack of knowledge by the management team of the people using the service or details relating to the provider would place people at risk of receiving care which was ineffective and did not meet their individual needs.

We asked the interim manager to show us how they monitored the quality of service provision. We noted some improvements had been made since our last inspection; however we still had concerns following this inspection. We were shown evidence of some audits taking place recently including those relating to infection control, quality and development and a training evaluation. We also saw checks detailing meals and records of food temperatures taking place.

There were details relating to care file audits; however we noted one of these had comments recorded but we could not see any actions from these. We saw copies of a health and safety audit in place and this identified that there had been an increase in the results since the previous audit, however we noted this had been dated from 2013. Documents relating to monthly checks for hoists inventory and hoist slings were seen however these were noted to be blank. Another audit for infection control was dated May 2014 however when we discussed this with the interim and the regional manager they found copies of a more recent audit in a separate file. Effective systems to ensure people who used the service were cared for in a home that had robust systems for quality monitoring were not evident.

The regional manager told us they had introduced a business continuity plan; we saw this had been completed recently. There was evidence of monthly provider visits taking place and we noted the date for the last review was July 2014. We were told that the provider had plans to introduce clinical meetings for staff to cover topics such as learning from incidents, training, communication and reviews.

We looked at how staff recorded incidents and accident in the home. The interim manager showed us a file that had details relating to accidents. There was guidance and policies in place to inform staff of the procedure to take if accidents occur. We saw evidence of forms detailing accidents that had occurred in the home. We saw evidence of a completed accident analysis log; however this had been dated June 2014. We discussed this with the interim and regional manager who provided us with copies of more recent analyses that had been stored in a separate file. One report we looked at identified actions that had been taken in response to accidents; however we noted on two occasions the family had not been informed of the accident and another entry had not been completed or signed and it lacked evidence of the outcome. We could not see effective systems of recording, reporting and analysis of accidents in the home.

During our inspection we identified some improvements had been made however we found there was still a breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not protect people who used the service against the risks of inappropriate or unsafe care and treatment, by means of effective systems to assess and monitor the quality of service provided.

We saw details in one person's care file relating to three accidents that had resulted in a hospital admission. One of these was documented on an accident form but did not detail the admission to hospital on it. The other two accidents were not documented on accident forms. In addition, the provider could not produce evidence that the accidents had been reported to the Care Quality Commission in line with their legal duty. This was confirmed by a check of our own records. This meant the provider did not have a robust system for collating, analysing and learning from accidents and incidents. This was a breach of regulation 18 (1) (2) (a) (iii) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider failed to notify CQC of accidents that had resulted in a hospital admission for review.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services.** **The registered provider failed to have suitable arrangements to ensure people who used the service were enabled to make, or participate in in making decisions relating to their care or treatment. Regulation 17. (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**