Care Quality Commission

Nethercrest Care Centre (Dudley) Limited BRAND Astonbrook Care Limited

Nethercrest Nursing Home

Inspection report

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Tel:
Website:

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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

Overall summary

This inspection took place on 3 August 2015 and was unannounced. The service provides care and accommodation with nursing for up to 41people who may have dementia and or physical disabilities. On the day of our inspection there were 37 people living at the home. This is a new legal entity previously under Mimosa Healthcare (13) Limited (in administration) and this is their first inspection.

The registered manager was present during our inspection. 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

Improvements were needed to ensure staff understood their role in recognising potential harm or abuse and in protecting people.

We found the arrangements for managing people's medicines needed improvement. The provider had input from other agencies to improve their management of medicines but had not sustained this.

Recruitment procedures had not been fully followed to reduce the risk of potentially unsuitable staff being employed.

There was enough staff to meet people's needs although people and their relatives had experienced some inconsistency in the way care was delivered. We found staff had not received the training required to meet people's needs.

Improvements were needed to ensure staff had regular supervision and support in order to reflect on their practice and develop their skills.

People with complex needs did not have regular and enjoyable mental stimulation and improvements were needed.

Staff did not understand the need to seek people's consent in line with the principles of the Mental Capacity Act . Staff worked within the principles of the Deprivation of Liberty Safeguarding (DoLS) and ensured people were not unlawfully restricted.

People told us food choices could improve and we found people did not always have the support they needed to eat their meals. Staff did not always monitor people's health care to ensure they minimised any risks.

Improvements were needed to support staff in communicating with people effectively and ensuring they promoted people's dignity.

People were not actively involved in planning their care and plans lacked personal information about their choices, routines and interests although staff had an understanding of these.

People knew how to raise a complaint and were confident they would be listened to. A complaints procedure was available in a suitable format for people to use and the provider had ensured concerns were addressed.

The leadership of the home had not been effective in sustaining the improvements needed to keep people safe. The ownership of the home had recently changed and the provider had a programme for improvement. Quality assurance audits were undertaken but did not identify some of the issues we found during our inspection and they had not sustained some of the new initiatives recently implemented.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not always safe.

Staff did not always recognise that people may be at risk of harm.

Recruitment systems were not robust to prevent the possibility of the employment of unsuitable staff.

The arrangements for managing people's medicines did not ensure people received them as they were prescribed.

Is the service effective?

Requires improvement

The service was not always effective.

People and their relatives felt their health needs were identified and met appropriately.

Peoples nutritional and hydration needs were met.

Staff were not provided with effective supervision or support to develop their skills.

People did not always have opportunities to make choices.

People's capacity was assessed and the decisions made for them were recorded.

Is the service caring?

Requires improvement

The service was not always caring.

People and their relatives described staff as caring.

Staff did not always understand the importance of communicating effectively with people who had complex needs.

Staff did not always promote people's dignity.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not actively involved in planning their care to reflect their choices, preferences and wishes.

There was a lack of daily activity based stimulation available to people.

People were confident that they could raise any concerns and that they would be dealt with quickly and appropriately.

Is the service well-led?

Requires improvement

The service was not always well led.

Summary of findings

There was a quality monitoring system but improvements were not always sustained to ensure people's needs were consistently met.

There was a lack of leadership structure and staff were not adequately supervised or trained although plans were in place to rectify this.

Nethercrest 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 August 2015 and was unannounced. The inspection team consisted of three inspectors 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. We looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission (CQC) about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These are called notifications and help us to plan our inspection.

We contacted other organisations such as the commissioners, Clinical Commissioning Group [CCG] and the safeguarding team for information. They told us that there had been medicine errors and incidents where people's care needs had not been met. We planned to look at these areas during our inspection.

We spoke with 12 people who lived at the home. 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. We spoke with four relatives, the registered manager, two nurses, seven care staff, the cook and domestic staff. We looked in detail at the care records for six people, and referred to two other people's care records for specific information. We looked at the medicines management processes, three recruitment files, records maintained by the provider about staffing, training, accidents and incidents and the quality monitoring systems.

Requires improvement

Is the service safe?

Our findings

The provider had notified us of a number of medicine administration errors. We were also informed by the local authority that as a result of repeated medicine errors in the home a pharmacist from the local Clinical Commissioning Group (CCG) had recently undertaken a medicines audit at the home which identified errors. These included omission of medicine doses due to lack of stock and medicine not being given as it was prescribed.

We looked at seven Medicine Administration Records (MAR) and found that people's medical conditions were not always being treated appropriately by the use of their medicines. For example we found the remaining balance of medicines for three people did not match the MAR. We also found gaps in some people's MAR where nurses had not signed these records to confirm people had their medicines. These gaps had not been identified by the nurses or registered manager. We saw no recorded explanation to explain why the medicine had not been given. These omissions meant we could not be sure people had their medicines when they should.

We found the provider's arrangements for ordering medicine were not effective. One person did not have their prescribed medicine available to them on the day of our inspection because the provider did not have any in stock. The nurse told us she was not made aware a prescription was needed. There was no evidence that nurses had reviewed or taken action to ensure people had sufficient supplies of their medicines.

We found that two of the seven people whose medicines we looked at in detail required their medicine to be given 'when necessary or when required'. Supporting information was not available for staff to refer to so that safeguards were in place for medicines to be administered safely. Whilst the nurse was able to explain when these medicines should be given, the MAR for one person showed their medicine was being given regularly and in discussion with the nurse it was evident this medicine was being given in 'anticipation' of behaviours. The absence of a written protocol to clearly describe the reasons/symptoms which would prompt administration meant that this person may be given the medicine when it was not needed. We checked incident reports and daily logs and found no entries that showed this person was displaying agitation or behaviours that might warrant the use of their medicine.

We saw the provider had not maintained safe systems that had been put in place as a result of the support from the CCG. For example, daily medicine audits were not consistent and the errors we found had not been identified. There was no evidence that handover of medicine issues had taken place or been recorded to ensure effective action was taken to ensure sufficient supplies of people's medicines. We also found an 'out of date' prescribed cream in a person's bedroom. The person confirmed staff had used it that morning and the two care staff we spoke with confirmed they had not checked the cream before application. A second person had a prescribed cream in their bedroom which was not prescribed for them, and a third person had dressings in their bedroom which were not prescribed for them. Nurses told us that clinical meetings had taken place in which they could discuss discrepancies and clinical concerns and a communication book was also in place. However neither had been used consistently. There was no written evidence that nurses had competency checks to ensure they administered people's medicines safely. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulation 12 (2)(g).

People who lived at the home told us that they were happy staff managed their medicines. One person told us, "Staff give me my medication every day but not always at the same time because they are busy". We saw that medicines were stored securely, including controlled drugs. The controlled drugs register was correctly completed when medicines had been administered and the balance of medicines matched the records.

People told us that they felt safe living at the home. One person said, "I feel safe and well cared for", and another person told us, "Staff are busy most of the time but would listen to me if I was worried". A relative told us their family member, "Felt very safe in the home and they did not want to leave". People told us they had sometimes experienced behaviour from other people that worried them, one person said, "I am happy and feel safe but when people start shouting it can be upsetting so I go to my room". Staff we spoke with told us that they had received training and we saw training certificates on their files for how to safeguard people from abuse. Although staff had received training our discussions with them identified they did not always recognise verbal intimidation as harassment or abuse. For example one staff said, "They can't hurt each other, it's only shouting".

Requires improvement

Is the service safe?

We saw that risk assessments had been undertaken to identify risks to people's safety. Plans were in place to guide staff on what they needed to do to support people with their fluids, and reduce the risk of falling or developing pressure sores. Staff we spoke with were aware of the risks to people's health and what they needed to do to keep them safe. We observed that staff used equipment such as pressure relieving mattresses and cushions to support people, and carried out repositioning interventions regularly throughout the day. People's monitoring records showed us that staff were recording interventions regularly at the desired frequency to reduce risks to people's skin, and to ensure they drank enough.

There were arrangements for monitoring and reviewing accidents, incidents and risks to people's safety such as the risk of dehydration, weight loss or pressure sores. We saw that these had not always been effective because a number of concerns about people's deteriorating health had not been recognised or reported by the staff but by visiting healthcare professionals. This indicated that the management of risks was not effective and that despite training staff did not always recognise that acts of omission placed people at risk of harm. We saw the methods used to share information on risks to people's care, were not consistently used. For example staff told us the communication book was the method of sharing updates but we observed at the handover we attended this was not used. We saw that the registered manager had taken appropriate staff disciplinary action where staff were responsible for unsafe practice.

Staff confirmed that checks had been undertaken on them before they were allowed to start work. One staff said, "I had to complete forms and a police check and provide references". We reviewed staff recruitment files and saw the provider's recruitment processes included a Disclosure and Barring Service (DBS) which had been undertaken before they took up post as well as proof of identity and completed application forms. However we saw that safe recruitment practices had not been followed in two of the three files we checked. For example we saw evidence of poor references and disciplinary action which had not been verified by the registered manager prior to the two people taking up post. We discussed this with the registered manager who told us that she had followed up on the references but had not documented this. There was therefore no documented evidence that safe recruitment had been undertaken to include the relevant checks on people before they started to work.

People told us that staff were sometimes rushed. One person said, "I sometimes have to wait for the carers to take me to the toilet". Another person said, "They can be busy at times but I don't mind waiting for a few minutes". One staff member told us, "Sometimes we are short; sickness is a problem, they [the registered manager] try and get cover, but it's not ideal". The allocation of nurses had decreased from two to one in line with the decrease in occupancy numbers. A nurse told us, "It is difficult to do everything". A relative we spoke with told us, "I think there should be more staff, but they do the best they can". We observed some people were asleep until mid day. We were told this was their preference although this was not documented. A staff member told us, "It can take a long time to get everyone up". We saw there were some delays in responding to people's requests for the toilet. There was also evidence that people's personal care had not been consistently attended to. The registered manager told us staff sickness and absence as well as competencies had impacted on the provision of consistent care. A review of staffing levels and competencies was underway to make sure there were sufficient staff to respond to people's needs.

Requires improvement

Is the service effective?

Our findings

People told us they liked the staff but that staff struggled to care for them in the ways they wanted. One person said, "Staff are always so busy it can be a bit rushed". A relative told us, "I assume the staff are trained but they are not always consistent and standards slip regularly".

We observed that staff had difficulty supporting people with complex dementia or mental health needs. We were told about one person who had behaviour which challenged the staff. The manager showed us how they were monitoring this behaviour and were in liaison with health and social care professionals for support. However, when we asked the staff about the training they had received to support this person they said they had not received any.

Relatives told us that consistency of care was an issue and that at times some staff did not show they had the skills or awareness to meet people's needs. A relative said, "Simple things like personal appearance, cleanliness, clothing; these get overlooked". Another relative said, "My main concern is stimulation; I don't see much appreciation from the staff in terms of talking with or doing things with people to keep them occupied".

During our inspection we observed staff's appropriate use of hoists and moving and handling techniques. Staff we spoke with were able to demonstrate their skill and awareness in terms of meeting people's pressure care needs and confirmed they had training in this area. The registered manager showed us a review of staff training needs had taken place and further training was planned

Staff told us they had an induction when they started work which included; getting to know people's needs, shadowing established staff and safety procedures. Two of the four staff files that we looked at for recent starters did not have documentary evidence that an induction process had taken place. A staff member told us, "I'm not sure everyone had a proper induction but it is changing now". The registered manager showed us that the new Care Certificate induction process which included training, mentoring and supervision to support new starters with developing the competences to deliver effective care, was being introduced so that staff had the skills to carry out their role and responsibilities effectively.

All of the staff we spoke with told us supervision was irregular which was confirmed by the records we looked at. One staff member said, "We've never really had proper regular supervision". A nurse told us she had not had regular supervision but had attended some clinical meetings in which nurses could discuss and share issues. Records showed there was a high turnover of registered nurses which the registered manager informed further complicated their capacity to oversee clinical practices in the home. We saw evidence that clinical nurse meetings had been arranged but on the last two occasions no one had attended. The provider recognised the need to develop staff competencies. They had introduced observational supervisions and a 'nurse competency day' was being arranged to support staff knowledge and skill.

People told us that they made their own day to day decisions about their care. One person said, "I make my own decisions about where I want to be; in my room or in the lounge, also what time I get up or go to bed". Another person told us, "I can refuse things like medicine, showers, meals and the carers would check with me first before doing anything". Relatives we spoke with told us that where people lacked capacity to make decisions about their care they were involved in meetings and discussions. Decisions made in people's best interests were documented. We saw very little evidence that staff asked people before carrying out care tasks. For example at breakfast and lunch we saw that food was given to people, we did not observe any choice being offered. People who had breakfast in their bedroom were given porridge or toast and staff were not observed to ask them first. We found by speaking with staff that they had limited knowledge of the Mental Capacity Act (MCA) and how this applied to their practice. We saw from training records that some staff had no training in this area. The registered manager showed us that training had been planned to address this shortfall.

The Care Quality Commission monitors activity under the Deprivation of Liberty Safeguards (DoLS). We saw appropriate referrals had been made to the supervisory body for people who might require their liberty to be restricted. The registered manager had followed these processes to ensure that people who lacked capacity were not unlawfully restricted in any way. We were told that one person had a DoLS authorisation. We saw that a MCA assessment had been completed and either an advocate or

relatives had been involved in this process. Staff we spoke with were able to describe what they needed to do to keep these people safe and the care plan contained information about how they should be cared for.

People told us that they did not always enjoy the meals and we saw they were not offered a choice of what to eat. Staff told us they did not always have time to ask people their food choices prior to mealtimes. One person told us, "There's never much choice in the meals that they give you just one thing on the menu most days, the same as the sweet course". Another person said, "The food is a bit of a hit and miss as some days it's not that good but they will give me something else if that happened". We saw the menu was displayed on the wall but the format was not suited to the needs of people, and those we asked could not see or read it. We observed that people did not always get the support they needed with their meals and drinks. For example we saw three people's meals were out of reach on small tables and they struggled to eat without dropping their food into their lap. One person was visibly tiring with the effort to take the food to their mouth which resulted with their meal on the floor. Whilst we saw staff replaced the meal the lack of effective support or use of appropriate utensils meant the person did not have the assistance they needed. A person was given a drink in a large mug but was unable to lift it.

We saw nutritional assessments with instructions regarding people's dietary needs were in place to guide staff with any risk of weight loss. Referrals had been made to the GP and or dietician or speech and language team where a weight loss was identified. Monitoring records were maintained to record people's food and drink intake to help reduce the risk of dehydration or weight loss. Weight checks had not been consistently recorded or transferred from the weights book to people's weight charts. It would be difficult to monitor any fluctuation which could result in deterioration in people's health being unnoticed. The information available to the cook regarding people's likes and dislikes was over a year old and had not been updated to capture people's changing needs.

People's health care had included the input of relevant health professionals. A person said, "The staff know my health needs and make sure I go regularly to hospital for treatment". Relatives told us that when their family member was ill they were updated and attended a 'health review' to inform them of changes in their care. A relative told us, "The staff have been marvellous in the work they have done to ensure my relatives pressure area has completely healed". The registered manager told us the high turnover of nurses had impacted upon consistency and there had been concerns about some nurse competencies. She had reviewed instances where nurses had not picked up on people's deteriorating health. She told us they were addressing this by reviewing nurse competencies and ensuring people had a plan which included clear instructions about their health risks and how to manage and monitor these.

Requires improvement

Is the service caring?

Our findings

We were told by the people who lived at the home that most of the staff were caring. One person told us, "Staff are fairly caring but always so busy so they don't always have time to chat to me". Another person said, "It depends who is on; some I know well and they are kind and caring, some I don't think have the right attributes, they rush and don't always talk". Some relatives described staff as having a caring attitude. One relative told us, "We are very pleased with the care shown towards our relative". Another relative said, "Some staff are very caring and intuitive; will take time and reassure people, but other staff seem unaware and not so good". Some of the staff had worked at the home for a long time and knew people well. During the inspection we observed some staff interacted with people in a friendly way and we saw people responded to them with smiles and chatter.

We saw that staff did not always communicate effectively with people who had complex needs. For example we observed one person sitting at an empty table from breakfast until lunch time, with very limited acknowledgement or interaction from staff who passed by. We saw no attempt to engage the person except for when a drink was offered. The person had no form of stimulus and was occupying themself by continually stroking their clothing. A staff member we spoke with told us, "They're quite happy". There was little recognition of the need to spend time with the person to ensure they felt they mattered. Our observations throughout the day showed people had little time with staff except for when staff assisted them with a drink or a meal. We observed most people dozed, slept or sat in their chair watching.

Very few staff we spoke with had an understanding of, or put into practice effective ways of supporting people to exercise choice. For example staff knocked on bedroom doors and said 'hello'. We only heard the registered manager tell the people when they entered their rooms who they were. This was important as many of the people had poor or no vision.

Most of the people we spoke with told us they had not been involved in planning their own care and did not know what was written in their care plan. Relatives told us that if health needs had changed they had been involved and concerns discussed with them. Care plans did not evidence people's involvement in planning their care. Most people told us that they felt staff would listen to them and that they would talk to staff if they were worried or upset about something. We saw on occasion staff responded to people's distress or confusion and offered comfort.

There was a lack of effective environmental cues to support people to exercise choice or independence. For example within the home there was no pictorial information for people to aid their understanding. The only easy read information we saw was within the complaints procedure. The menu was out of reach and people could not see it or read it. There were very few pictures on the walls or time recognition information for people to orientate what time of day or day of the week it may be. People's bedrooms had little decoration or evidence of personalisation to aid people to recognise them.

People told us that staff respected their privacy and dignity. One person said, "I feel my privacy and dignity is protected by the staff". We saw staff offered clothes protectors at mealtimes, however we observed one person still had on a clothes protector late into the afternoon. The registered manager walked through the lounge and noticed and asked the person if they could remove it. This demonstrated staff did not have a good awareness of promoting people's dignity where they could not do this for themselves. Similarly at mealtimes the lack of effective support and utensils compromised people's dignity and independence further. We heard from a relative there had been more than one occasion when they were unhappy about the lack of attention paid to their relatives appearance. On the day we saw this person and confirmed their personal care was lacking. There was a lack of consistency in the caring approach of staff. We were told by the registered manager and from information in the hallway that the home was going to undertake work for dignity champions. This was to have been discussed at the clinical nurse meetings but no one attended.

We were told by relatives that staff were respectful when they visited and staff made them feel welcome. A person who lived at the home said, "It's not perfect but I'm happy enough, I feel respected by staff so I don't have any complaints there". Some people told us they had been encouraged to maintain their independence. One person said, "I choose my own clothing and when they assist me with a wash I do it myself with them doing bits I can't manage". People said staff would listen and respect their decisions; one person said, "I can tell them when I want to

Requires improvement

Is the service caring?

go to bed or get up and they will help me, also if I don't want to be in the lounge they respect that and help me to my room". Relatives felt staff were respectful towards people, one relative told us, "I have always seen them being polite and respectful, and they are patient but most of these people need time and company".

Requires improvement

Is the service responsive?

Our findings

We last inspected this service in March 2014 and found the provider was not meeting the requirements of the Health and Social Care Act 2008. People 's care was unsafe and the observation of and response to their changing needs was not consistent. The provider sent us an action plan outlining how they would make improvements. At this inspection we found the provider had taken action to ensure people's plans contained sufficient up to date guidance about how staff should support people's changing needs. However we found further improvements were needed to ensure people's plans were personal to them and included their choices and preferences as to how they wished their care to be delivered.

People told us that when they first came to live at the home staff had asked them how they wanted to be supported and what they could do for themselves. One person said, "I don't know if my care is written down anywhere but the carers know what I need doing". Another person said, "I haven't been asked what care I need but the carers know what to do for me".

A relative told us, "If there are any concerns staff will call me at home to discuss the issue. I'm also involved in any changes to the care plan". Another relative told us, "We are very pleased with the care and we are involved in all the care plan meetings, they communicate well".

Whilst care plans had evidence of how to support people's needs only basic information was recorded about the individual. Plans were not personalised with useful information which could be used to improve people's care and quality of life. For example we saw no evidence within care plans of consultation with people who used the service. We noted people's level of understanding and communication abilities had not been determined. We saw people who staff told us had dementia, with no form of stimulus and no recognition in their care plan of their hobbies, interests or how to communicate and engage with them. There was a lack of meaningful conversation with people, particularly those people who struggled to communicate because of their dementia. We saw staff did not always utilise opportunities to initiate conversation, for example when supporting people to eat staff did not always talk to the person.

There was a designated activities coordinator but the hours available were not effective to provide activities for the numbers and needs of people in the home. We saw an activities programme which included the hairdresser, nail care, and visiting singers and representatives from the church visited regularly. People told us they enjoyed the planned events such as fetes and had enjoyed an ice cream van visiting on occasions, but on a daily basis felt there was little to do or to look forward to. One person said, "I don't have any expectations, I know they are busy and can't entertain everyone, I sit here and see what happens; mostly us watching them". We saw people spent a large portion of the day sitting or dozing, unoccupied with only minimal staff contact. We could not see any evidence of the recognition of the mental health stimulation needs of people

Relatives we spoke with also expressed concern about a lack of regular stimulation. They said staff had little contact with people to talk with them. One relative said, "I do worry because my relative has to spend time in bed, they miss out a lot". Staff told us they had reminiscence items, craft materials and games but these were not visible and not used on the day we visited. We did not see any newspapers or magazines or games used to engage people. Within the living areas of the home there was a lack of household items, pictures or photographs on display. Many of the walls were painted with no pictures or decoration. The home is promoted for the care of people with dementia; however there was little evidence of staff being aware of the support needs of people with dementia. Staff we spoke with recognised the importance of social contact and companionship but this was not happening consistently. One staff member said, "It takes time and patience; most people here would respond if we had time to sit with them".

Relatives told us that they had attended meetings and completed surveys in which they could feedback their views about the care. One relative told us, "They are receptive and I have no problem raising concerns and they do put it right". Another relative told us, "When I have wanted to talk about my relative's care the manager has always done something about it".

People had access to a complaints procedure in a format that suited their needs. Complaints had been recorded,

Requires improvement

Is the service responsive?

investigated and the outcome feedback in a timely manner. We saw complaints had led to improvements in the way staff delivered people's care. For example staff were able to tell us how monitoring people's skin care had improved.

Requires improvement

Is the service well-led?

Our findings

People we spoke with knew who the registered manager was. One person told us, "I often see her, she will come and say hello and ask how I am". A relative told us, "We feel well treated by staff and the manager who is very approachable".

People and their relatives told us they had no complaints about how the home was managed, but recognised some areas could be better. For example more stimulation for people, and more time for staff to sit and talk to people. Some staff we spoke with, spoke highly of the registered manager. They said she was always willing to listen and act upon concerns. The registered manager managed two homes on the one site which at times took her away from the nursing home. Some staff told us the registered manager was not available as often as they needed. The registered manager told us the volume of continual analysis of shortfalls had impacted on her capacity to support and direct staff and therefore sustain improvements. The registered manager said that despite training and disciplinary actions, improvements in the quality of care had been difficult to achieve and the high level of sickness and absence had also impacted on this.

We saw that staff supervision and clinical meetings were not established in order for staff to reflect on their practice and develop their skills. A staff member said, "I haven't had supervision in ages, I don't need it I've worked here for years". Most staff told us that they felt supported by the registered manager but they had not received regular supervision. Although we saw staff meetings were regularly arranged not everyone attended. We also saw that other methods of communication with staff had been utilised such as messages in the communication book and memo's. However we saw staff did not always act on these. For example the handover we observed did not include reference to the communication book, medicines had not been re-ordered to ensure there was a sufficient supply, people's weights were not consistently recorded and people's daily diaries had not been updated as requested. It was not evident that staff understood their roles and responsibilities and the lines of accountability were not clear.

There had been recent changes to the management team structure to include a new deputy who was also identified as the new clinical nurse lead. Nurses we spoke with told us that their clinical supervision had been irregular and disrupted by the turnover of nurses in the home. They felt this in turn impacted upon their capacity to maintain clinical consistency. There had been issues where a lack of nurse competencies had contributed to a lack of effective care for people. The registered manager told us that a new supervision structure to include clinical supervision for nurses and review of nurse competencies was planned to ensure nurses had the right skills to recognise and manage people's deteriorating health needs.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC) of important events that happen in the home. The registered manager had a system in place to ensure incidents were reported to the CQC which they are required to do by law. This showed that they were aware of their responsibility to notify us so we could check that appropriate action had been taken. Staff knew about and had used the whistleblowing policy where they were concerned about care practices or the conduct of their peers.

The registered manager had systems in place to review people's care and safety. There had been investigations into the contributing causes of incidents and disciplinary action had been taken with staff for poor practice. Some changes had taken place since the new provider took over in April 2015. The registered manager was supported by a wider management structure that included an operational manager, and a quality assurance team who were also providing staff training. The registered manager was using a management tool to provide the provider and the external quality assurance team with an oversight of how the service was performing. This included information about the number of accidents, falls, safeguarding, complaints and disciplinary action. These audits identified what action had been taken address any deficits or shortfalls in practice areas, so that plans for improvements were appropriately shared with the provider's external management team. This ensured there was a clearer line of accountability and the support and resources needed to run the service could be more readily available.

We saw that some improvements were planned and some already implemented. A review of staff training had taken place with a plan in place to address gaps. However we also saw where improvements had not been sustained

Requires improvement

Is the service well-led?

such as repeated medicine errors and incidents where standards of care had fallen, despite guidance to staff. Monitoring of the service needed improvement to ensure risks to people were fully mitigated.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with the management of their medicines. Regulation 12(2)9g)