Care Quality Commission

Mr. Liakatali Hasham

Kings Lodge Care Centre

Inspection report

The Pavilions
West Byfleet
Surrey
KT14 7BQ
Tel: 01932 358700
Website: www.chdliving.co.uk

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Ratings

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

Overall summary

The inspection took place on 13, 14 and 20 May 2015 and was unannounced.

The service provides accommodation, nursing and personal care for up to 42 older people, some of whom are living with dementia. There were 31 people living at the service at the time of our inspection.

There was no registered manager in post at the time of 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.

The previous registered manager had resigned in February 2015. A peripatetic manager had been appointed by the provider to support the service but had left the day before our inspection.

People told us that they had seen several managers join the service and leave shortly afterwards, which meant there was no consistent leadership for staff or direction

Summary of findings

for the service. Morale amongst permanent staff was low. One member of staff told us, "Managers have changed so often. It's not good, we need stability" and a relative said, "My father's been here less than a year and we've seen four managers in that time. There's no consistency."

People told us that the peripatetic manager had improved the leadership and support provided to staff and, as a result, the care people received. Staff said the peripatetic manager had introduced supervisions and encouraged them to raise any concerns they had. One member of staff told us, "She made sure things were running properly. I felt confident going to her if I had a problem. She listened and tried to help. She was really for the residents." Another member of staff said, "She was very good, she really knew what she was doing. Things were starting to improve under her." Relatives and care staff expressed concern that the improvements begun by the peripatetic manager would not be continued following her departure. One relative told us, "She was starting to turn things around. I'm very worried to hear that she's gone."

The area manager said a new permanent manager had been appointed and would start work in June 2015. The area manager told us that, until then, management cover for the service would be provided by two managers of other registered care services operated by the provider and the provider's operations director.

There were not enough staff available to keep people safe and meet their needs in a timely way. People routinely had to wait for long periods when they needed care or support and during our visit insufficient staffing levels put one person at risk of harm.

There was a heavy reliance on agency staff, which meant that people did not receive consistent care from staff who knew their needs well. Some staff did not have sufficient knowledge of people's needs to ensure that they received the care they required. Medicines were not managed safely.

People had not always given their consent to the care they received and the provider had not consulted relevant others to ensure that decisions were made in people's best interests. Staff did not have an adequate knowledge of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Some people had to wait a long time to be served their meals and hot meals were sometimes cold by the time they were served. There were not enough staff on duty to support all the people who needed assistance with eating. This resulted in one person almost choking as they ate their meal unsupervised. Staff were not always aware of guidelines for supporting people with eating.

People did not have sufficient opportunities to take part in activities. The premises had not been adapted to meet the needs of people living with dementia.

We identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe.

There were not enough staff to keep people safe and meet their needs in a timely way. During our visit insufficient staffing levels put one person at risk of harm.

Medicines were not managed safely.

There were not enough staff employed to maintain appropriate standards of hygiene and infection control.

People were kept safe by the provider's recruitment procedures.

There were procedures for safeguarding vulnerable adults and staff were aware of these.

The provider had a business continuity plan in place to ensure that people's care would not be interrupted in the event of an emergency.

Is the service effective?

Inadequate

The service was not effective.

The service had high vacancy levels on the permanent staff team and relied heavily on agency staff. This meant that people did not receive consistent care from staff who knew their needs well.

Staff had not been adequately supported and they did not feel confident in some areas of their practice. Staff told us that they had not had opportunities to discuss their training and development needs.

The provider had not always obtained people's consent to the care and treatment they received or consulted relevant others to ensure that decisions were made in people's best interests. Staff were not sufficiently aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People at risk of inadequate nutrition or hydration were not monitored affectively.

The service did not have an effective system in place to ensure that people received their food in good time and had the support they needed to eat it. Staff who supported people to eat were not always aware of their individual support needs.

Staff did not share information effectively with other professionals involved in people's care and treatment.

The premises had not been adapted to meet the needs of people living with dementia.

Summary of findings

Is the service caring?

Requires improvement 

The service was not consistently caring.

People did not always receive their care from staff who were familiar to them.

People told us that the permanent staff were kind and helpful.

Relatives told us that the permanent staff were caring and sensitive to their family members' needs.

We observed that permanent staff supported people in a kind and sensitive manner and knew their likes and dislikes.

Is the service responsive?

Requires improvement 

The service was not responsive to people's individual needs.

People did not have sufficient opportunities to participate in meaningful activities.

People had been asked for feedback about the service they received, including activities they would like to try, but their views had not been acted upon.

People's needs had been assessed before they moved into the service but their needs had not been regularly reviewed to ensure that their care continued to reflect their needs.

Is the service well-led?

Inadequate 

The service was not well led.

There had been a high turnover of managers, which had had a destabilising effect on the service.

Staff had not been supported by effective leadership and did not feel that their concerns were listened to.

Relatives and care staff told us that the peripatetic manager had improved the leadership and support provided to staff and the care people received but they were concerned this may not continue.

The standard of record-keeping was inadequate, which meant that staff and other healthcare professionals did not have access to accurate records of people's care and treatment.

Kings Lodge Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on 13, 14 and 20 May 2015 and each visit was unannounced.

The inspection was carried out by two CQC inspectors, a CQC pharmacy inspector 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.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, including safeguarding referrals, which had occurred since the last inspection. We spoke with the local safeguarding authority and the local authority quality assurance team that monitored the service. We also spoke with healthcare professionals who visited the service.

During the inspection we spoke with 14 people who lived at the service and six relatives. We also spoke with 12 staff, including care assistants, nurses, domestic staff, the clinical lead, a team leader and the area manager. We observed how people were being cared for by staff. We looked at the care records of six people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at four staff recruitment files and other records relating to staff support and training. We also looked at records used to monitor the quality of the service, such as the provider's own audits of different aspects of the service.

Our last inspection of the service took place on 25 October 2013, at which time the provider was meeting the standards we assessed.

Inadequate

Is the service safe?

Our findings

People and their relatives told us that there were not enough staff available to provide care in a timely way and to keep people safe. They said they often had to wait a considerable time for staff to attend if they rang their nurse call bells. One person told us, "There are not enough staff. You can't always find one when you need one." A relative told us that on several occasions they had been unable to locate a staff member to assist them when their family member had become unwell. The relative said, "There are never enough staff around. The carers always seem stressed by the workload." Another relative told us, "There just aren't enough of them. The carers just don't have the time to spend with her."

Staff told us that there were not enough of them on duty to provide the care people needed. One member of staff said, "We're too rushed, especially in the morning. There's so much to do with the number of staff we have. Sometimes we're still washing people at lunchtime." Another member of staff told us, "There's not enough staff to cope. We don't get breaks because there's not enough staff to cover" and a third said, "There's not enough staff on the floor, it's impossible to get it all done. Sometimes there's no time to do the tea trolley and people aren't washed and dressed until lunchtime. If you want to give people the right care, you have to have time to focus on them."

Staff told us that many people required two members of staff to support them and that this meant other people often had to wait for their care. One member of staff said, "If we are helping one person who is a double-up with hoisting for transfer, other people who need our help have to wait." Another member of staff told us, "We try to do everything properly but we don't have time. They always have to wait." A third member of staff said, "Residents are not getting the care they should be receiving. We don't have enough time to spend with them. We don't even have time to take our breaks."

During our visit insufficient staffing levels put one person at risk of harm. The person suffered a choking incident while eating their meal unsupervised in their bedroom. The person's care plan identified that they had diagnosed swallowing difficulties and needed supervision at all times when eating. The member of staff responsible for supporting the person to eat was supporting two other people to eat in their bedrooms simultaneously. Staff told us they were aware the person should be supervised at all times while they were eating but said there were insufficient staff available to enable them to do so. One member of staff said, "We know some people need supervision but there's not enough staff to keep an eye on them." We told the area manager about this incident and advised them to make a safeguarding referral to the local authority. Following the inspection we received confirmation from the local authority that the safeguarding referral had been made.

We observed during our inspection that staff provided support in a task-oriented way as they did not have sufficient time to spend with people before moving on to another person who needed their help. We asked to see the dependency assessment tool used by the provider to calculate the staffing levels needed to ensure that people's needs were met. We were advised that there was no specific dependency assessment carried out to calculate the required staffing levels. This meant that the provider could not be assured that staffing levels were sufficient to meet people's needs and keep them safe.

Failure to deploy sufficient staff to meet people's needs and keep them safe is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Checks of medicines storage and equipment had not been routinely recorded in recent months, which meant that management had no way of ensuring that medicines were managed safely or recorded accurately. According to the records seen, insufficient supplies were available to complete one person's course of antibiotic, although all prescribed doses were recorded as administered. The provider clarified that the person had received the correct dose of antibiotic over the correct period of time but there was a discrepancy in recording as a second bottle of antibiotic had not been appropriately recorded on the MAR chart. Letters were in place to authorise any medicine given covertly but there were no mental capacity assessment for these decisions.

The directions for medicines to be administered only when needed (PRN) were not meaningful. There was a profile sheet at the front of each person's medicine administration record (MAR) chart. This included a named member of staff as a key nurse for that person. For several people the key

Is the service safe?

nurse identified had left employment at this service. One person's medicine prescribed PRN was dated over a year ago and there was no evidence of review since the initial prescription.

Failure to manage medicines safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems for ordering, checking orders received, disposal and administration were in place to manage people's prescribed medicines. Boxed medicines stocks were counted to confirm available stocks. The doctor visited weekly to review people's healthcare needs as their condition changed. Any medicine dose changes following a doctor's visit were carried out as per instructions.

Housekeeping staff told us that there were not enough cleaners employed to maintain appropriate standards of hygiene and infection control. They said that shifts were often covered by domestic staff supplied by agencies and that agency staff regularly failed to complete cleaning schedule checklists. We checked the cleaning schedule checklists for shifts that had been covered by agency staff and found that these had not been completed. This meant the provider could not be sure that all areas had been cleaned to an appropriate standard. We also found that some items were stored inappropriately, which presented a risk of cross-contamination. For example we found that cleaning equipment such as buckets and mop heads were stored with clean laundry, including bed linen and pillows.

We recommend that the provider implement best practice guidance in the prevention and control of infections.

People were kept safe by the provider's recruitment procedures. Prospective staff were required to submit an application form, with the names of two referees, and to provide proof of identity and proof of address. The provider had obtained a criminal record check for staff before they started work and made a check against the barred persons list. We saw evidence that applicants were appointed following an appropriate recruitment procedure, including a face-to-face interview.

There were written procedures for safeguarding vulnerable adults and these were displayed in the service. Information about safeguarding adults was also provided to people living at the service and visitors. Staff were able to describe what they would do if they suspected someone was being abused or at risk of abuse. The service manager had reported allegations of abuse to the local safeguarding authority and the Care Quality Commission when necessary.

The provider had a business continuity plan in place designed to ensure that people's care would not be interrupted in the event of an emergency, such as power supply failure, fire or adverse weather event. This included the provision of alternative accommodation for people if necessary. There were appropriate emergency procedures in place and each person had a personal evacuation plan which detailed their needs should they need to evacuate the building.

Inadequate

Is the service effective?

Our findings

People did not receive consistent care from staff who knew their needs well. The service had high vacancy levels on the permanent staff team and relied heavily on agency staff to cover these vacancies. This was compounded by the fact that people's care plans were not kept up to date, which meant agency staff could not be sure that the guidance within them accurately reflected people's needs and the way in which their care should be provided.

People and their relatives told us that care was provided by many different staff, some of whom did not know people's needs. A relative told us, "There are too many agency staff. Their level of understanding of people's needs is lacking. They sometimes haven't got a clue." The relative said they had written their family member's basic care needs on a sheet and displayed it in their bedroom to ensure that agency staff provided care in the way their family member needed it.

Staff also expressed concern about the reliance on agency staff and the effect this had on the care people received. One member of staff said, "The agency staff don't know what they are doing. I had to show an agency carer how to change an incontinence pad." Another member of staff told us the use of agency staff affected the permanent staff team in addition to compromising people's care. The member of staff said, "There are a lot of agency staff who don't know the residents, which means that the permanent staff have to do everything. We're totally overworked."

Failure to ensure that people received their care and treatment from staff who had the competence, skills and experience to provide it safely is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they did not have access to all the training they needed to feel confident in their practice. They said they had an induction when they started work at the service but the majority of training was provided via e-learning, which they told us was ineffective. One member of staff said "Moving and handling training is no good. Staff need to be shown how to use slings and measure residents properly." Another member of staff said, "E-learning is no good, it's just ticking boxes." The provider's staff training record indicated that a significant proportion of staff had not attended all mandatory training in line with the provider's training policy.

Staff told us that that they had not been well supported through the supervision and appraisal process in the past. They said that the peripatetic manager had introduced regular supervision, which they had found valuable as they had been able to discuss issues that concerned them and their training and development needs. One member of staff told us, "If you had a problem, she was willing to listen, she was very approachable." And another said, "I'd only had about three supervisions in five years before [peripatetic manager] got here. She was trying to change things for the better. She supported me all the time." Staff told us they were not confident that supervisions would continue following the peripatetic manager's departure.

Failure to ensure that staff received appropriate support, training, supervision and appraisal is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence that the provider had obtained people's consent to their care and treatment. People's care plans contained consent to care and treatment forms. These forms were intended to demonstrate that people, or an appropriate person acting on their behalf, had given their consent to the care and treatment they received at the service. However none of the consent to care and treatment forms that we saw had been completed or signed.

Staff were not sufficiently aware of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA protects people who may lack capacity and ensures that their best interests are considered when decisions that affect them are made. DoLS ensure that people receive the care and treatment they need in the least restrictive manner. Staff told us that they were unclear about what this meant for them.

We asked staff what they understood about the MCA and DoLS. One member of staff told us, "For people who lack capacity, you have to make a decision for them." Another member of staff said they had heard of the MCA but was unable to describe how the Act affected the care provided to people living at the service. A folder contained policies

and procedures relating to the MCA and DoLS and an instruction to staff to sign when they had read and understood the policies. The signature sheet was blank, which meant there was no record that staff had read and understood the policies in relation to the MCA and DoLS.

We observed that bed rails had been installed on many people's beds. We checked care records for four people for whom bed rails had been installed and found that the provider had not carried out an assessment to determine whether bed rails were necessary or whether there was a less restrictive option. This meant that people's liberty was restricted without authorisation as the provider had failed to consider the least restrictive option in the provision of their care and treatment.

Failure to gain people's consent to their care and treatment is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had been identified as at risk of inadequate nutrition, there was no evidence that their weight was consistently recorded to identify any significant change in weight. In cases where food and fluid charts had been implemented to monitor people's nutrition and hydration, we found gaps in recording. This meant that people were at risk of not receiving adequate food and hydration to maintain good health.

Staff who supported people to eat were not always aware of their individual support needs. We asked a staff member who was supporting a person to eat how they knew what support the person needed. The staff member told us that they had not read the person's care plan or any guidance about the support the person needed to eat. The member of staff was not able to tell us the person's name. This meant that the person was at risk of receiving inappropriate or unsafe support.

The service did not have an effective system in place to ensure that people received their food in good time and had the support they needed to eat it. The service had communal dining rooms on the ground and first floors. We observed that people in the first floor dining room did not receive their meals until after 1.30pm, although they had been seated at the table since 12.30pm. Staff told us that it was common for people in the first floor dining room to wait a long time for their meals. One member of staff said, "The old system worked. Everyone got their lunch on time, no problem with timings or food. Nobody had to wait. It's not organised properly now." Another member of staff told us, "There must be a better system. People are waiting. We are still feeding people at 2.15pm. Meals are getting cold."

On the second day of our inspection we observed that a heated trolley had been brought to the first floor dining room to keep people's food hot until it was served. However the trolley was not plugged in, which meant that the food had gone cold. We asked the member of staff who was serving the food how the heated trolley worked but they were unaware that the trolley needed to be plugged in.

Failure to meet people's nutritional needs is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained 'hospital passports' for use in the event that a person was admitted to hospital. The 'passports' were intended to provide information for hospital staff about the person's medical history, medicines and diagnoses. However none of the 'passports' had been completed in the care plans we checked. This meant that hospital staff would not have access to the information they needed should a person be admitted to hospital.

One relative told us that they had requested that the service provide them with up to date information about their family member's medical history and diagnoses in order that they could supply it to medical staff at a forthcoming appointment. The relative said that the service had failed to provide this information as requested, despite the request being made well in advance of the appointment. The relative told us that the lack of information hindered the medical staff's ability to make an accurate diagnosis.

We recommend that the provider implement best practice guidance in sharing information with other healthcare professionals.

People told us they were able to see a doctor if they felt unwell and that they had access to the treatment they needed. A GP made a weekly visit to the service and additional visits if required. We spoke with a visiting healthcare professional during our inspection, who told us that staff referred people for treatment appropriately.

The premises had not been adapted to meet the needs of people living with dementia. There was no evidence that

Inadequate

Is the service effective?

best practice in environmental design for people living with dementia had been considered or adopted in order to support peoples' independence and dignity. There was no evidence of colour coding, signage or visual aids to assist orientation or identification on to assist people to finding a bathroom for example.

We recommend that the provider implement best practice guidance in environmental design for people living with dementia.

Requires improvement

Is the service caring?

Our findings

Due to the high usage of agency staff, people did not always receive their care from staff who were familiar to them. One person told us, “There’s no consistency of care. I see different faces every day.” Another person said, “The carers are good but different all the time.” Relatives also told us that the care their family members received was provided by many different staff.

People spoke highly of the care provided by the permanent care staff team. They said that permanent staff were kind and caring. People told us that they had good relationships with the permanent staff and that staff treated them with respect. One person told us, “The regular staff are really good; they can’t do enough for you” and another said, “They’re very good and very helpful.” Another person said of the permanent staff, “They’re dedicated. They’re very understanding and kind.”

Relatives also provided positive feedback about the care provided by the permanent staff. They said that permanent staff were caring and sensitive to their family members’ needs. One relative told us, “The permanent carers are good, they work really hard” and another said, “There are some good and committed carers here.” Relatives said that staff made them welcome when they visited and kept them informed about their family member’s welfare, if they became unwell or had a medical appointment.

The staff we spoke with who had worked at the service for some time knew the likes and dislikes of the people they cared for and their preferences in terms of their daily routines. We observed that staff supported people in a sensitive manner, engaged with people while supporting them and maintained their comfort when providing their care. Staff were proactive and positive in their interactions with people and spoke with people in a respectful way.

People had access to information about their care and the provider had produced information about the service, including how to make a complaint. The provider had a written confidentiality policy, which detailed how people’s private and confidential information would be managed. Staff understood the importance of maintaining confidentiality. People told us that they could have privacy when they wanted it and that staff respected their decisions if they chose to spend time in their rooms uninterrupted. Staff understood the importance of respecting people’s privacy and dignity. They spoke to us about how they cared for people and we saw them attending to people’s needs in a discreet and private way.

Requires improvement

Is the service responsive?

Our findings

People and their relatives told us that not enough activities were arranged. They said that they had been asked what activities they would like to see but their suggestions had not been implemented. One person told us, "I'd very much like to go out into the garden but I need someone to walk with me. I've mentioned it a number of times but it hasn't happened." A relative said, "I've suggested more small group activities like painting and jigsaws. That would be so beneficial for my mum but they haven't been organised." No activities took place during our inspection and many people spent long periods of time without stimulation or interaction with others. The activities board listed craft and gardening as the activities planned for the first day of our visit but neither of these took place. Care staff told us that they had no time to organise activities.

People had been asked for feedback about the service they received, including activities they would like to try, but their views had not been acted upon. For example the notes of a residents' meeting in January 2015 recorded the activities people said they would like to see organised. These included gardening and the purchase of a table tennis or pool table. People also said that they would prefer the computer available for them to access the internet moved from the reception area to the lounge. At the time of our visit, people had not had the opportunity to try gardening, neither a table tennis or pool table had been purchased and the computer was still in the reception area.

We recommend that the provider improve the systems used to collect and respond to people's feedback about the service they receive.

People's needs had been assessed before they moved into the service. People and their relatives told us that they had been asked about their preferences regarding their care prior to their admission. However people's needs had not been regularly reviewed to ensure that any changes in need were identified and their care plans updated accordingly. The six care plans we checked were overdue for review. The dates listed in the care plans for the next scheduled reviews were 14/06/2013, 04/09/2013, 12/10/2013, 25/11/2014, 04/01/2015 and 10/02/2015. We asked one person if we could check the care plan in their bedroom to determine when it had last been reviewed. The person told us, "I wouldn't bother reading that, it's all out of date." The version of one person's care plan in the office recorded that they had no allergies to medicines but the care plan in the person's room listed two medicines to which the person was allergic. This meant that the person could be at risk of receiving medicines to which they were allergic.

Failure to ensure that people's care plans accurately reflected their needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a written complaints procedure, which detailed how complaints would be managed and listed agencies complainants could contact if they were not satisfied with the provider's response. Information about how to make a complaint was available in the service. We checked the home's complaints record and found that any complaints received had been investigated and responded to appropriately. People told us they would feel comfortable making a complaint if they needed to and knew how to do so.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. The previous registered manager had resigned in February 2014. A peripatetic manager had been appointed by the provider to support the service but had left the day before our inspection.

People, relatives and staff told us that the high turnover of managers had had a destabilising effect on the service. They said that the frequent changes of manager had led to a lack of effective leadership. One member of staff told us, "Managers have changed so often. It's not good, we need stability and we need to trust the manager" and a relative said, "My father's been here less than a year and we've seen four managers in that time. There's no consistency."

Relatives told us that the permanent staff team had not been supported by good leadership. One relative said, "There are some good carers here but they need leadership and support." Relatives told us that the peripatetic manager had improved the support provided to staff and, as a result, the care people received. One relative said, "She was very good, she was really trying to improve things."

Care staff told us that they had not been well supported in the past. They said that morale amongst permanent staff was low due to staff shortages and ineffective leadership. Care staff confirmed that the peripatetic manager had improved the leadership and support available to them. They said the peripatetic manager had introduced supervisions and encouraged them to speak with her if they had any concerns. They told us that the peripatetic manager had arranged regular team meetings at which they were encouraged to contribute their views. One member of staff said, "With her we had meetings and we were asked for our opinions, it was good."

Care staff said that the peripatetic manager had made clear her expectations in terms of standards of care and had challenged practice where necessary with the intention of improving the care people received. One member of staff told us, "She was strict but for good reason. She made sure things were running properly. I felt confident going to her if I had a problem. She listened and tried to help. She was really for the residents." Another member of staff said, "She was very good, she really knew what she was doing. Things were starting to improve under her."

Relatives expressed concern that the improvements begun by the peripatetic manager would stall following her departure. One relative told us, "She was starting to turn things around. I'm very worried to hear that she's gone." The area manager said a new permanent manager had been appointed and would start work in June 2015. The area manager told us that, until then, management cover for the service would be provided by two managers of other registered care services operated by the provider and the provider's operations director.

The standard of record-keeping was inadequate, which meant that staff and other healthcare professionals did not have access to accurate records of people's care and treatment. A healthcare professional who visited the service regularly told us that they made notes of their appointments and gave these to staff to store on people's care records. The healthcare professional said that staff were often unable to locate these notes when requested to do so at subsequent visits. This meant that the healthcare professional was not able to monitor people's treatment effectively.

The failure to maintain accurate, complete and contemporaneous records in respect of the care provided to people is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a quality monitoring system in place and evidence that the provider carried out regular monitoring visits. The provider had implemented a system of audits to monitor key areas of the service including fire safety and health and safety. The provider's operations director and area manager had carried out a quality monitoring visit in April 2015. The provider had drawn up a service improvement plan in response to the shortfalls identified during the quality monitoring visit. Whilst the quality monitoring visit had highlighted a number of areas that required improvement, it had failed to identity all the shortfalls we found during our inspection.

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 **Regulation 12 (2)(g) HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment** The registered person had failed to ensure that medicines were managed properly and safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14 (1)(4)(a)(d) HSCA 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs** The registered person had failed to ensure that service users received suitable and nutritious food and hydration and, where necessary, support to eat or drink.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 (1)(3) HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care** The registered person had failed to ensure that the care and treatment provided to service users met their needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	**Regulation 17 (2)(c) HSCA 2008 (Regulated Activities) Regulations 2014 Good governance** The registered person had failed to maintain accurate, complete and contemporaneous records in respect of the care provided to people.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1)(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing** The registered person had failed to ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff available at all times to safeguard people's health, safety and welfare. The registered person had failed to ensure that people received their care and treatment from staff who had the competence, skills and experience to do so safely. The registered person had failed to ensure that staff received appropriate support, supervision and training to enable them to deliver care and treatment safely and to an appropriate standard.

The enforcement action we took:
We served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent** The registered person had failed to obtain people's consent in relation to their care and treatment.

The enforcement action we took:
We served a warning notice.