Mr D & Mrs S Mayariya

Fairfield Care Home

Inspection report

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Ratings

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

Overall summary

We carried out this inspection on 17 September 2015. The inspection was unannounced.

Fairfield Care Home is registered for a maximum of 21 people offering accommodation for people who require nursing or personal care. At the time of our inspection there were 18 people living at the service, two people were in hospital.

A requirement of the service's registration is that they have a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was no registered manager in post and there had not been since April 2013. The previous manager had left in August 2015 after six months in the role. A new manager was in post, and had been there for five weeks at the time of this inspection. They told us that they intended to apply for registration as registered manager of the service.

Summary of findings

At our last inspection on 8 February 2015, we identified a breach of regulation in relation to how the provider monitored and assessed the quality and safety of service provided. At this inspection we found that improvements had not been made and the provider continued to be in breach of this regulation. Inconsistency of management and leadership at the service meant, at times, the quality and safety of care people received was not satisfactory. For example safety checks of equipment were not consistently completed, audits of complaints, accidents and incidents had not been carried out, records were not kept securely and people were not asked for their views about the service.

People and staff told us they could raise concerns with the management team who were approachable. However, continued changes in management, meant staff did not always feel supported in their roles and opportunities for staff to discuss their work performance, learning and development were limited.

A small number of quality monitoring audits had been undertaken but these did not identify the concerns we found around assessing the quality of the service. These included shortfalls in staff knowledge around MCA and DoLS, and that other staff training had lapsed. Care records and risk assessments had not been updated. There had been no staff meetings since May 2015. The provider did not respond formally to complaints, and people had limited opportunities to be involved in the running of the service. Accidents and incidents were recorded but not analysed. Fire drills had not been carried out since December 2014. The provider had not displayed their last inspection rating as per the legal requirement to do this.

People told us they felt safe living at the service. Staff were trained in safeguarding adults and understood how to protect people from abuse. There were some processes to minimise the risks to people's safety, however these were not always reviewed as people's needs changed.

Medicines were administered as prescribed, and stored and disposed of safely. However, there were no protocols for medicines given 'as required,' so we could not be sure these were given consistently or correctly. There were enough staff to provide the support people required in order to meet their needs and preferences. Checks were carried out prior to staff starting work to minimise the risk of recruiting unsuitable staff to work with people who used the service.

People told us staff were respectful and had the right skills to provide the care and support they required. However, we did not see people being supported with dignity and respect at all times, for example people were not always afforded privacy by being able to lock toilet doors.

People told us they enjoyed the meals provided, were offered choice and different dietary needs were met.

The manager and staff had some understanding of the principles of the Mental Capacity Act 2005 (MCA). However mental capacity assessments were not always completed correctly, so we could not be sure the rights of people unable to make decisions for themselves were being protected.

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 consistently safe.

People told us they felt safe and staff were confident in how to safeguard people from abuse and actions to take if they had concerns. Risk assessments did not reflect the current risks to people's health and wellbeing. Medicines were stored safely and people received these as prescribed, however there were no protocols for medicine taken 'as required' to ensure they were administered consistently. Staff were available at the times that people needed them and recruitment checks reduced the risk of unsuitable staff being employed at the service.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff received some training, but this was not always kept up to date. Referrals were made to other professionals to enable people to maintain their health and wellbeing. Staff had some understanding of MCA and DoLS, however decisions were not always made in people's best interests and capacity assessments were not always completed correctly. People enjoyed the meals and different dietary needs were catered for. A choice of food was offered and people could access drinks and snacks to suit them.

Is the service caring?

Requires improvement

The service was not consistently caring.

Everyone we spoke with told us staff were caring in their approach and we saw examples of this during our visit. Overall, the care provided by staff ensured people were cared for with dignity and respect but people were not always afforded privacy at the service. Staff involved families in decisions about people's care.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People did not always receive person centred care, however, staff had some understanding of people's individual needs and preferences. Care plans were not always updated to reflect people's current health and care needs. Group and individual activities were on offer for people at the service. People knew how to raise complaints and these were responded to, however as the response was not recorded we were unsure if this was to people's satisfaction.

Is the service well-led?

Inadequate

The service was not well led.

Summary of findings

There had been no registered manager in post since April 2013 and there had been frequent changes of manager at the service. Continued changes in management had resulted in inconsistent leadership being provided. Arrangements to monitor the quality and safety of the service were ineffective and people and staff had limited opportunities to put forward their suggestions about how to drive improvement of this. The last inspection rating was not on display as is the legal requirement.

Fairfield Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 17 September 2015 and was unannounced. The inspection team comprised of an inspector and an inspection manager. The inspection was carried out following a safeguarding concern we received about the service and further changes within the management team.

We reviewed the information we held about the service. We looked at information received from relatives and visitors, we spoke to the local authority commissioning team and reviewed the statutory notifications the manager had sent us. A statutory notification is information about an important event which the provider is required to send us by law. These may be any changes which relate to the service and can include safeguarding referrals, notifications of deaths and serious injuries.

We spoke with six people who lived at the service, one relative and one health professional. We also spoke with three care staff, the provider, the manager, the deputy manager, and the cook. We looked at four care records, six medicine administration records and the quality assurance checks made by the manager. We observed the way staff supported people at the service.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. One person told us, "Yes I have always felt safe, so far anyway!" Prior to staff starting at the service, the provider checked their suitability to work with people who lived there. This included contact with their previous employers and the Disclosure and Barring Service (the DBS is a national agency that keeps records of criminal convictions). This was to minimise the risks of recruiting staff who were not suitable to support people who lived at the service. Staff we spoke with told us background checks were completed before they were able to start work. We looked at two personnel files and saw checks were completed along with further assessments of people's suitability for employment, where this was applicable. The provider ensured that, as far as possible, the staff employed were suitable to support people who lived at the service.

Staff told us they understood how to safeguard people and they had received recent training about this. One staff member told us, "It can be about keeping the environment safe, pressure sores, it could be about verbal abuse or discrimination." Another staff member told us, "I have had training about physical, emotional and sexual abuse, I would report it to my manager." Staff were aware of the possible different types of abuse, actions to take to protect people, and we found safeguarding concerns were reported appropriately.

We looked at how the provider identified and managed risks associated with people's care. The management team told us they updated risk assessments each month or when risks changed. We saw this had not always been done. For example, one person had been admitted to hospital in June 2015 with bowel problems. Their care records stated daily monitoring of bowel movements were required, however nothing had been documented since early July 2015 apart from on one occasion. We asked the deputy manager about this and they were not aware of when the person last had their bowels open and whether the record was accurate or not. Their medicine chart showed that they had refused the medicine prescribed for this health condition and actions had not been taken about this. We discussed this with the deputy manager who told us that she would liaise with the person's GP about this. She also told us that the cook had increased the fibre in the person's diet, however this was also not recorded. The same person had been assessed as being at risk of weight loss but it was unclear if they were to be weighed weekly or monthly. Records show that they were weighed weekly up until early August 2015, but there no record of their weight being recorded since and staff had no other information about this. It was noted, however that the cook and other staff had a good understanding of this person's dietary requirements in relation to weight loss and a dietician had been involved in their care and treatment. Staff understood the risks to some people's care, however without up to date risk assessments, there was the potential that risks would not be monitored and care provided would not meet people's needs.

We looked at whether staff were available at the times that people needed them. One person told us, "They could do with another one, but they just get on with it." Another person commented, "Staff? Sometimes, there is enough, sometimes there isn't," and this person went on to say, "When I press my buzzer they are very quick and I don't have to wait." A staff member told us, "If the staff were all here there would be enough," referring to some current staff absences. Another staff member told us, "No, there is not enough staff, we need a few more at nights."

We discussed this with the manager who told us that existing staff had covered the gaps in the staff rota for staff absences and staff vacancies. This had resulted in a staff member working an excessive number of hours during the previous week. The manager told us that agency staff were used on occasion to cover absences. There was no 'dependency tool' used (a dependency tool is used to determine the level of dependency of the person and how many staff hours are required to ensure their needs are met). The manager confirmed they had discussed this with the provider and would be introducing one. Overall there was enough staff to care for people but at times, with staff absences, staff were unable to support people at the times they preferred.

We looked at how people's medicines were managed. One person told us, "I get my medicine when I should, I have heart problems and I get it on time, they're very strict about that." Senior staff were trained to administer medicines, medicine was administered from blister packs and stocks were audited by the deputy manager. The manager told us they had recently requested locked boxes for people's

Requires improvement

Is the service safe?

prescription creams which were kept in their bedrooms for additional safety. Medicines were stored securely and in line with manufacturer's guidelines, then disposed of safely to ensure people were protected.

We reviewed the medicine administration records (MAR) of six people, and these were completed correctly. This meant we could be assured people were receiving medicines they were prescribed. However, records for 'as required' medicines did not always provide sufficient information to support the safe administration of these medicines. For example, one person was given 'as required' medicines for 'agitation'. There was no plan of care (protocol) which described how the decision should be made to administer the medicine for the person's agitation. This meant staff might not administer 'as required' medicines for the same reasons and lead to inconsistency of administration. The newly recruited deputy manager, who was also the lead person for medicine management, told us they would address this now.

Some checks had been undertaken to assess the safety of the service. Accidents and incidents were recorded, however these records had not been analysed to identify any trends which may assist staff in preventing recurrences.

We saw fire equipment had been serviced recently; however there had been no fire drills since December 2014. The manager told us they were aware of this and were arranging one. Each person had a personal emergency evacuation plan which detailed their care and mobility needs in an emergency, however the manager was not able to find these straight away and they were not dated. There was a risk of information not being available and up to date in an emergency.

The manager had made a 'grab bag' of essential items such as torches to use in an emergency and there was a contingency plan should they need to go to a different service for support. Emergency lighting was tested monthly and last tested in August 2015. There was no maintenance person employed at the service and the provider completed any repairs required or used external people. People were supported to remain safe in an emergency but some improvements were required.

A CCTV system had been installed in communal areas of the service. The provider told us these had been fitted to ensure people were safe following an incident where the front door had been left open and another incident where there had been a theft. One person told us about the cameras, "It's a good idea for safety and I am glad." We saw signs were displayed notifying people of the cameras and the provider had met with people to ensure they had consented to these being installed.

Requires improvement

Is the service effective?

Our findings

People told us staff had the skills and knowledge to care for them effectively. One person told us, “Everything is good with the care, I could not grumble," and another person described the staff as ‘excellent’. A relative told us, “I am happy, I’ve got no concerns with staff.”

Staff were made aware of their job roles when they first starting work at the service but the induction training was not comprehensive. One staff member who had recently started working there told us, “I had a tour of the service and met staff; I asked lots of questions but did not ‘shadow’ anyone.” However the person explained they were a ‘fast learner’ and an experienced care worker, so they felt that this was enough to support them.

Staff received training relevant to the health and social care needs of the people who lived at the service. One person told us, “Yes, the staff are qualified, they know what they are doing.” However one staff member told us, “Training? I have not received so much lately.” The deputy manager told us, “Training is being arranged currently, we are starting to understand what training is needed,” and explained they had already identified training had not been available for staff recently to support them in their roles. The deputy manager was completing an NVQ 5 in health and social care currently. We saw there had been training in some areas such as manual handling in January 2015 and infection control in March 2015. Training had lapsed with the change of management; however this was now being resumed for staff.

Staff told us they received supervision from their line manager which made them feel supported. One to one meetings were held around every four months, with the last meetings for staff taking place in July 2015 with the previous manager. One staff member told us they had raised a concern about a personal issue in their supervision and they had felt supported by the manager with this.

Communication between staff assisted them to provide continuity of care to people they supported. A ‘handover’ meeting was held at each shift change where information was passed on to staff about any changes to people’s health or well-being. We observed the afternoon handover meeting and saw people’s health and care needs were discussed in detail with staff. The manager told us they planned to introduce a staff communication book as well to complement this.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act is a law designed to protect adults who are unable to make decisions for themselves, and protects care workers and others who may have to make decisions on behalf of those who lack capacity.

We asked staff if they understood the principles of the Mental Capacity Act. A senior member of staff was unaware a mental capacity assessment could be carried out by staff. One person’s care record informed us the person, because of their health condition, lacked capacity to make their own decisions. There was no record to tell us what action had been taken by staff to support decisions which had been made in the person’s best interest. Another person, had an exact copy of the other person’s notes in their care record. We raised this with the manager who was unable to tell us why this had been duplicated. The manager told us that there were a small number of people at the service living with dementia, they knew how to undertake capacity assessments and these would be reviewed now.

The manager understood their responsibilities to apply for a Deprivation of Liberty Safeguard (DoLS) when people’s freedom was restricted. The manager told us they understood that an application for a person who lived at the service, had been sent to the local authority by the previous manager. This referral was made as the person lacked capacity and frequently tried to leave the service. There was no copy of the DoLS application on the person’s care record or any other related paperwork, so we were unsure if this had been done or not and the manager told us they were unclear about this also. They told us there was another person who they intended to apply for a DoLS for now. We could not be sure people who may be being deprived of their liberties were having their freedom legally restricted.

People told us staff asked their permission before assisting them with care. One person told us, “The care is very good and they always ask me first.” The deputy manager told us, “If a person declines care I would talk with their family or the GP,” and they told us this decision would be respected.

Requires improvement

Is the service effective?

People had a choice of food which met their dietary needs and preferences. One person told us, “The cook is good.” Another person told us, “The food is more than edible; there is not much I leave.” A relative told us, “[Person] is well fed, they have snacks between meals.” The cook told us they spoke with people individually to ask what they would like to eat and offered alternatives to the main meal available. On the day of our visit home-made trifles, bread and cakes had been made. We saw fresh fruit was available and the cook told us they were in the process of sourcing local suppliers to provide more fresh produce at the service. People were given a choice of food and the manager and cook were working towards ensuring that more fresh food of a good quality was provided.

People’s dietary needs and preferences for reasons of health were catered for. One person required food to be softened, other people had diabetes and another person was losing weight and needed a ‘fortified’ diet. The cook had a good understanding of these people’s dietary needs. For example we saw that they served smaller portions to one person who had a reduced appetite so they were not ‘put off’ by a large meal, and this had proved successful in encouraging them to eat.

People were able to access drinks when they required and one person told us, “Yes I get enough to drink.” During lunchtime one person had fallen asleep and we saw a staff member gently wake them up to remind them that the meal was there. Another staff member was present in the dining room and this person was encouraging other people with their meals as required, at their own pace. The lunch time meal looked appetising and was well presented.

Overall people were supported by staff to access health professionals when this was required. One person told us, “Yes they refer me to the optician and the dentist.” Another person told us, “Yes they get the chiropodist in for my feet.” We saw on care records that referrals to health professionals had been made and on the day our visit the GP was visiting one person. A relative told us that their family member had regular contact with the GP and since their medicine had been altered they were more happy and content. However, within one person’s care records we saw that a recent hospital appointment had to be cancelled due to staffing issues at the service. The deputy manager told us they would discuss this with the GP now.

Requires improvement

Is the service caring?

Our findings

People we spoke with were positive about the care staff. One person told us, “The staff are really nice and caring. They will sit and talk with you if you feel a bit down.” Another person told us about the staff, “If you are not very well, nothing is too much trouble for them.”

People told us staff treated them with dignity and respect. One person told us, “Yes I respect them and they me, I say, sorry if I am a nuisance and they say, you’re not a nuisance.” Another person told us staff were ‘very respectful’. A staff member explained about dignity and respect, “We cover people with a towel when they are washed, people wash themselves where they want to; if we apply a cream we would say it is cold and try to reassure them, try to make them relax.” During our visit we saw one person became upset when asked if they wanted to join in the exercise session and staff respected their decision not to. However, we also saw two instances when staff were not respectful. We heard a staff member describe a person who had been upset saying, “They kicked off big time today,” and a different person was described on their care records as ‘a wanderer’ because they were sometimes confused and walked around the service. This labelled the person by their actions and did not consider the person’s needs. We raised this with the provider and manager who agreed this was not respectful.

People were not always supported to have privacy whilst living at the service. People could not lock their rooms if they wished to. Both toilets on the ground floor were used by people at the service and we saw neither of them could be locked, so people could not be sure they could use the toilet without being disturbed. We asked the manager about this and they told us this was intentional so people could not lock themselves in the toilet accidentally. The manager told us they would replace the toilet locks so they could be locked now, but opened on the outside in an emergency. This would provide people with privacy, whilst also keeping them safe. We saw one person getting dressed in their bedroom and as their window was opposite the conservatory, we could see them but they did not realise this. The manager alerted the person and agreed they would buy some net curtains for their room now.

We heard some good examples of when staff and others that supported them were caring. One person told us about the hairdresser, “I have had my hair done today. She comes in every Thursday, she doesn’t overcharge.” One person liked handbags and a staff member had bought them a new bag and the person showed us this. The provider told us that one staff member had bought a projector and music for people to enjoy. The manager told us they tried to do ‘little things’ to make people happy, for example staff bought people fish and chips from the chip shop to eat 'traditionally' in newspaper, which people said they enjoyed.

Relatives were encouraged to be involved in their family member’s care. A staff member told us, “Families come to us and talk to us, we are open with them.” A visitor told us they were involved in their relative’s care and could discuss any issues they had with staff. Where people were able to bring their own belongings, or had relatives who could bring personal mementos, rooms were personalised.

Requires improvement

Is the service responsive?

Our findings

People we spoke with had positive views about how their care and support needs were met. One person told us, "The staff are marvellous, very good." A relative told us about their family member, "[Person] seems happy, staff genuinely care for them, they seem occupied."

Prior to people coming to live at the service a pre-admission assessment was completed. We saw one had been completed on the day of our visit and this was comprehensive, covering areas such as the person's history and preferences. The manager told us that they completed these assessments to ensure people's needs could be suitably met at the service.

Care records did not always reflect people's changing needs. The manager told us care plans should be reviewed monthly, however we found that one care record sampled had not been updated since May 2015. The record stated that the person had a urinary catheter but staff confirmed that this had been removed several months ago. A staff member told us, "I get told about changes in the handover, I don't look at the care plans." Staff told us they knew people and they felt the handover meeting provided them with the information they required to support people.

One person could become upset and angry with staff and we were aware there had been a number of incidents recently. Referrals had been made to other professionals; however there was no care plan or guidance for staff about how to support this person. Their care plan stated, " I do get confused at times and can be forgetful," but there was no information recorded about any possible triggers for this, what staff should do or when to give the medicine prescribed for this. The care plan provided information about the social activities this person liked to take part in, however this had not been updated to reflect a significant change in their family circumstances around four months ago, which had an impact on how their social care needs were to be met. People care records had not been monitored and updated to reflect changes in people's health and social care needs to ensure they were supported effectively.

We saw there was some information recorded about people's histories, likes and dislikes on care files which enabled staff to know people they cared for better. For example, the manager told us one person who lived at the service was well travelled and with their agreement, they had purchased a map of the world to put in their room so they could plot all the countries they had been to. Another person had requested a visit from the local priest, as this was very important to them and this was being arranged. We saw a person had requested a certain gender of care staff and this was being provided. Staff used this information to support people based on their individual preferences.

During our visit we saw that there were some people who became anxious and required regular assurance from the staff. One person could become upset and a staff member told us, "[Person] sometimes get 'agitated,' I try to talk to them, offer them a drink, let them know I am there." We saw another person repeatedly ask where their relative was and were worried about this. Staff were sympathetic and tried to distract the person. The provider told us they had tried to use Skype for them to see their relative, who could not always visit, but this had not been successful. We discussed other ways in which the staff could support this person and the provider said they had not considered this before but would now. Staff had some skills in supporting people and managing their individual needs, but these could be improved further.

Staff told us people were encouraged to be involved in reviews of their care and contribute to these discussions. One person told us about reviews, "Yes, families can come to the meeting if they want to." A staff member told us, "Families are invited to meetings." A keyworker system was being introduced and we saw details of this in people's bedrooms. This included an explanation of their roles, to give people a consistent staff member who could get to know them well.

People were involved in a variety of activities at the service. On the day of our visit an exercise class was being held and we saw some people joining in with this, although it was evident that other people in the room were not interested in this activity. One person told us, "I've got enough to do here, they are going to do bingo." Another person told us about activities, "It's there if you want it, I don't want to always get involved, I am quite happy." They went on to say, "They take me out if I want to." However, another person told us they would like to go out more and used to go out for lunch more often. We saw one staff member playing dominoes with a person and another staff member playing scrabble with a different person. A 'race' night was being

Requires improvement

Is the service responsive?

arranged and there were plans to introduce a gardening club. People told us they had enough to do, were supported with 'one to one' activities and had some opportunities to pursue their own interests.

People were aware of how to make a complaint if they wished to. One person told us, "I've no complaints, I am very fortunate but I could tell them if I had." A relative told us, "We've got no complaints." We saw the provider's complaints policy was in each person's room and on display on the notice board in a communal area. The policy required updating as the previous manager was named as a point of contact on this. A suggestions box was placed in the reception area, and we saw suggestions leaflets placed on the main reception desk. Two compliments had been received in July 2015 thanking staff for the invitation to the garden fete.

One complaint was received in July 2015 from a family member requesting their relative's bathroom was decorated and highlighting that a leak had not been repaired. We saw an email had been sent by the previous manager to the provider on the same date to advise the complaint had been received; however there was no evidence of a response to this. We asked the provider about this and they told us that actions had been taken, the bathroom had been decorated and the leak fixed. People had the opportunity to raise any concerns, which were responded to by the management team. However as these were not documented we were unsure if the responses were to people's satisfaction.

Inadequate

Is the service well-led?

Our findings

At the time of our last inspection undertaken on 6 February 2015 the provider was not meeting the requirements of the regulation in relation to good governance. This was because the systems in place to assess, monitor and mitigate risks relating to people's health, safety and welfare did

not ensure that people using the service were sufficiently protected. The provider sent us an action plan outlining the improvements they would make. At this inspection we found that there continued to be concerns in this area and improvements had not been made.

There had been no registered manager in post at the service since April 2013. The current manager had been in post five weeks and intended to apply for registration. The previous manager had worked at the service for six months and had not applied for registration, despite the provider being aware that this was required. The management team consisted of a manager, deputy manager and three senior care staff. There had been some recent staff changes and the deputy manager had been in post for three weeks. The deputy manager told us that on her first day working at the service staff had not been made aware of the post she had been appointed to. Additionally, the deputy manager had not been made aware of the previous concerns that had been raised about the service and frequent changes in management. Staff told us of their frustrations about the changes in management. One staff member told us, "There has been that many managers here, when is it going to settle down?" Staff told us they were unhappy with all the changes, and would like there to be some consistency in the management of the service. The frequent change of managers had resulted in inconsistency of leadership at the service.

The service had been inspected twice in 2014, and on both occasions we found concerns with infection control procedures. Whilst we did not find a breach of regulation in relation to this at this inspection, checks on the cleanliness of the premises had not been undertaken. Within the laundry we found soiled clothing had been left on top of a bag designed to store soiled linen. This presented a risk of cross infection.

The provider has a legal duty to display their last inspection rating. On the day of our visit we saw the ratings poster was not on display, a copy of the report was on the noticeboard. The provider and manager were not aware of this requirement and told us they would ensure the ratings were subsequently displayed.

Since 2013 the provider had appointed a consultancy company to undertake audits of the quality and safety of service provided at the service, on their behalf. However, despite these checks being undertaken each month, many of the issues found during our inspection had not been identified as part of the quality assurance process. This meant that actions had not been undertaken to drive improvement for the benefit of people who lived at the service. This included shortfalls in record keeping, care planning, risk assessing and staff knowledge of the MCA and DoLS. We asked for a copy of the audits completed, however we were not provided with these.

The provider did not respond formally to complaints they received and accident and incidents were recorded but not analysed to identify any patterns or trends. Fire drills had not been carried out since December 2014 so we could not be sure people would be safe in an emergency. Staff training had lapsed and a system to ensure that there were enough staff available in order to meet people's needs and preferences was not in place.

There had not been any staff meetings recently, the last one being in May 2015. This meant that the staff team had not had the opportunity to put forward their suggestions about the running of the service together as a group.

People had limited opportunities to be involved in the running of the service and offer their suggestions to improve the service they received. We saw 'resident's questionnaires' had been completed in February 2015 and there were nine responses. Staff supported people to complete the questionnaires by writing people's comments on the form. Whilst staff did this to assist people, we were concerned people may have felt unable to answer as they would want to. All the responses given were positive except for one person who said 'medication at night should be given earlier.' Nothing was recorded about actions taken in response to this feedback. Arrangements had not been made to seek the views of relatives, carers, staff and other stakeholders in order to obtain their views on the quality of service provided, in order to drive improvement.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities)

Inadequate

Is the service well-led?

Regulations 2010, which corresponds to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The newly appointed manager told us they were committed to the continual improvement of the service and the care people received. A coffee morning had been arranged in September for people and relatives to come to the service and meet the staff. There were no group meetings involving people who lived at the service however the manager told us they were planning to arrange these. We asked people if they were asked about the way the service was run. One person told us, "No, I'm not involved in the running of the home." However, they went on to say, "I would not make any changes, I am quite happy living here." People were not involved in formal discussions to offer any suggestions they had.

Some people we spoke with were positive about the service and the provider's management team. One person told us, "The home is very good, there is a new manager, they are very nice, they have not been here long." A relative told us, "There has been a change in manager, the new manager seems good." A staff member told us, "I have no problems but if I did I would go to the owner or manager." One professional told us, "I am positive about how the home has been in the last couple of weeks. I have not met the manager yet, but the deputy manager is very motivated and knowledgeable."

The manager provided 'on call' support to the staff team outside of their working hours. They told us that plans were in place for the deputy manager to also provide support with this and that the provider was also available to contact at any time. We asked the manager what their priorities were currently and they told us, "Care planning and staff recruitment." The manager told us they completed observations of staff practice daily which they called 'Sit and See,' so they could assess any areas which required improvement. They told us they planned to introduce staff 'champions' covering our five key questions of safe, effective, caring, responsive and well-led. New equipment had been ordered recently including alarm mats. The manager had implemented a 'daily room check' chart to identify any issues in people's bedrooms such as cleaning or repairs required. The deputy manager showed us a medication audit template that they planned to start implementing and told us, "[Manager] and I work well together." A professional told us that the pharmacist was going to do an audit of medicine shortly also to support staff.

During our visit, the manager told us the local authority had not visited recently but were due to visit soon. This was because during their previous visit they had identified a number of shortfalls in relation to the service provided and they were re - visiting the service to check whether improvements had been made.

The manager was able to tell us which notifications they were required to send to us so we were able to monitor any changes or issues with the service.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to monitor and improve the quality and safety of services provided, and to manage risks related to the health, safety and welfare of people, were not effective. This included records not always being sufficiently detailed and accurate to support safe and appropriate care. Regulation 17 (1) (2) (a) (b) (c)

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