Niram Investments Limited

Widecombe Nursing Home

Inspection report

36 Grasmere Road
Luton
Bedfordshire
LU3 2DT

Tel: 01582505575
Website: www.widecombenursinghome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 30 November 2016 and was unannounced. When we last inspected the service in June 2016, we rated the service as 'requires improvement'. We returned to the service to carry out a further comprehensive inspection due to an increase in concerns about the safety and effectiveness of the service raised by the local authority.

Widecombe Nursing Home provides accommodation, personal and nursing care for up to 38 older people, some of whom may be living with dementia or physical disabilities. The service also supports people who require palliative and end of life care. At the time of our inspection, there were 34 people using the service.

There was no registered manager in post, however a new manager was in place and intended to make an application to register. 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 2008 and associated Regulations about how the service is run.

Some improvements had been made in the assessment of staffing numbers, but there were still issues with the regular deployment of sufficient staffing numbers. People consistently told us that staffing numbers at weekends were too low. Because of the high needs of people using the service, there were not enough staff deployed during the night to keep them safe.

The quality of people's care plans had improved and were now more person-centred and reflective of people's changing needs. However there was not always evidence of how people or their relatives had been involved in the care planning process. There were risk assessments in place which detailed control measures that could be taken to keep people safe. However the management of behaviour which might have impacted negatively on others was not always fully accounted for. People's healthcare needs were met although pressure relieving equipment was not always set at the correct weight. People had enough to eat and drink and had their choices and dietary needs met. Medicines were accounted for correctly, but the storage arrangements were not always safe. The environment was kept safe and was subject to regular health and safety checks. There were emergency evacuation plans in place for people and contingency plans in case of emergencies affecting the service.

The requirements of the Mental Capacity Act 2005 (MCA) were met, but not always recorded appropriately within care plans. People provided consent to the delivery of their care and support.

People felt their regular staff were kind and caring, and we observed good practice around the home. However the high use of agency staff meant that people did not always receive consistent care from staff who knew them and understood their needs. People were encouraged to share their views through key worker meetings, but outcomes were not always evidenced in response to comments they made.

Staff felt supported, but reported being under pressure due to staffing shortages and changes in management. Supervisions and appraisals had been infrequent, but the manger had recently begun to carry out some supervisions with staff. New staff were recruited safely and received a full induction to the service when they joined. Meetings were held frequently to enable them to contribute to the development of the service.

There was a manager in post who was not yet registered with the Care Quality Commission. While there had been some improvements since our last inspection, the changes in management meant that there were still shortfalls in the service which had not been addressed. There were regular audits carried out to identify improvements that needed to be made across the service.

During this inspection we identified one breach 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 the report.

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.

While some improvements had been made to the assessment of staffing numbers, there were still persistent staff shortages which left people at potential risk of harm.

There were risk assessments in place to support people safely. However these still did not always include protocols for the management of behaviour which may have impacted negatively on others.

People's medicines were accounted for correctly, but storage arrangements were not always safe because action had not been taken in response to high temperature readings of the fridges.

People's pressure relieving equipment was not always set correctly and left people at risk of developing pressure ulcers.

Is the service effective?

Requires Improvement

The service was not always effective.

Understanding of the Mental Capacity Act (2005) had improved, but references to DoLS (Deprivation of Liberty Safeguards) were not always appropriate within people's care plans.

People had their healthcare needs met, but there were some gaps in recording and care planning.

Staff had not always been supported with regular supervision and appraisals, although most had received a recent supervision.

People had enough to eat and drink and had choices over the food they ate.

Is the service caring?

Requires Improvement

The service was not always caring.

Time constraints and staffing pressures meant that people did not always receive a person-centred service.

High use of agency staff meant that people did not always receive consistent care and support from staff who knew them and understood their needs.

People were treated with dignity and respect and spoke highly of their regular staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

While there had been improvements in the quality and detail contained within care plans, there was not always evidence of involvement from people and their relatives.

People did not have access to regular activities through the day to provide stimulation.

There was a complaints policy in place, but some low level complaints were not always being recorded or responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A change of management had slowed the rate of improvement within the service and actions were not being taken within acceptable time frames to address persistent issues.

There was a new manager in post who intended to register with the Care Quality Commission (CQC).

People did not always have opportunities to have their views or opinions heard, and there was not always evidence of outcomes in relation to suggested improvements.

Widecombe 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 the 30 November 2016 and was unannounced. The inspection was carried out by one inspector, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of nursing and dementia care. The specialist advisor was a registered nurse.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We reviewed local authority inspection records and asked for feedback from nine professionals involved with the service.

During the inspection we spoke with nine people who used the service and seven of their relatives to gain their feedback. We spoke with the registered manager, deputy manager, and six members of the care staff.

We observed the interactions between members of staff and people who used the service including their routines and mealtimes. We reviewed the care records and risk assessments for eight people who used the service. We checked medicines administration records, and looked at staff recruitment and training records. We looked at complaints and compliments received by the service. We also reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection in June 2016 we found that there was no formal method in place for assessing staffing dependency. Shortages of staff resulted in long response times when people requested help, and rotas were not always managed effectively.

During this inspection we found that while some improvements had been made to the deployment of staff, there were still not always enough staff available to meet people's needs. When we asked people if there were enough staff, most told us they felt staff were rushed and under pressure. One person said, "Staff are very busy. I am not the only one who needs help and I do have to wait sometimes." Another person said, "It depends on the time of day if you get a quick response as staff are so busy all the time." We asked the staff about this and some agreed that a lack of staffing had put pressure upon the existing staff team. One member of staff said, "We are short of staff here as so many residents need a high level of support, and we really do need more staff."

Of the 34 people using the service, 32 required some level of support with their personal care or assistance from two members of staff. This meant that if people wanted to move, then they would have to wait until two members of staff were available. During the night there were two care staff deployed alongside a nurse. This meant that if one person required help with moving or personal care from two members of staff, then only one member of staff would be available to attend to people across the rest of the building. We found the higher needs of many people using the service meant that this level of staffing was unsafe and put people at unnecessary risk of harm or neglect. One person we spoke with told us, "It is worst at night. If you need help then, you might as well not bother to be honest. There's just not enough [staff] to get round us all."

During the day there were usually six members of care staff deployed in addition to at least two nurses. When we reviewed the rota, we noted that the number of staff deployed at weekends was always lower than the weekday allocation, and that the use of agency staff was higher. The manager explained the challenges with recruitment and staff adjusting to a new pattern of working, and told us they planned to look at how resources were deployed in future. For example they explained that they had made having an extra member of staff during the night a priority and communicated this need to the provider. While there were signs of gradual improvement being made to address this on-going issue, not enough had been done to keep people safe from the potential risk of harm they were exposed to by insufficient staffing numbers.

Following our visit to the service we requested further information in relation to staffing at night and asked to provider to tell us what action they were planning to take to address the risk. The provider informed us that from the 8 December a fourth member of staff would be deployed at night, which meant that the staffing levels had now been assessed as being safe. This meant that appropriate measures were taken immediately to protect people from any associated risk of harm.

The management of the service rotas had improved and there was now a more accurate record available of which members of staff were working. The new manager was also able to demonstrate how they had

considered the needs of the people using the service when considering how best to deploy the team. For example we noted that one person had been assessed as requiring continuous one to one care due to their higher level of need. There had also been a change in shift patterns so that staff worked a continuous twelve-hour shift through the day. We received mixed responses from people and their relatives when we asked how this was working. One relative told us, "The new manager has changed the shifts which meant good staff left as it didn't suit them. I have seen staff in tears because of the pressure they are under." However the manager explained that the change had been planned prior to their commencing the role and was designed to promote a greater consistency of care for people who used the service. The manager said, "Handovers between shifts were time consuming and this means that everybody understands their role throughout the day."

People who required pressure-relieving equipment for the prevention or treatment of pressure ulcers did not always have the correct settings applied. We noted that two pressure mattresses were set at over 100kg when the people concerned had recorded weights of 54kg and 74kg. For newer pressure relieving mattresses, there were 'high and low' settings but it was not clear which of these was correct for each person. We did note that information relating to pressure area care was contained within care plans and that people's weight was displayed in their rooms. However failing to set their equipment to the correct weight left people at unnecessary risk of their skin integrity deteriorating. When we raised these issues with the manager and deputy manager, they took immediate action to resolve this.

Each person had detailed risk assessments in place which covered a variety of aspects of their care. We saw risk assessments which covered mobility, tissue viability, falls, malnutrition and dehydration, and continence needs. These were personalised and included measures that could be taken to effectively mitigate these risks. However during our last inspection in June 2016, we had noted that there were not always protocols in place for the management of behaviour which may have impacted negatively on others. While we did see some information in relation to people's mental health needs and communication, we found that improvement was still required in risk assessing incidents of aggression. We noted in one person's nursing notes that there were several references to the person being 'aggressive' and refusing care. However this was not reflected in adequate detail in their care plan. This meant the service did not always have a consistent approach to managing aggression or understanding the causes and triggers.

Medicines were administered safely by nursing staff who had been trained and assessed as competent to do so. The service was using a new system since our previous inspection which used a handheld electronic device to scan barcodes to account for each person's medicine. The staff were positive about the ways in which this had helped to reduce errors and make the medicine rounds faster and safer. For example if a medicine was missed, then staff were alerted and unable to complete further rounds until this had been rectified. Controlled medicines were well managed and subject to regular audits and stock checks.

The temperatures of storage fridges had been monitored on a daily basis. While the low reading was satisfactory, the high reading was recorded as twenty-four degrees which is above acceptable parameters. On speaking with the nurse on duty and the deputy manager, they were unaware that this had been a problem and that it had been happening for at least two months prior to the inspection. This may have caused the medicines stored in the fridge to lose its effectiveness and could have caused harm to people if administered. The deputy manager was advised that they needed to consider removing and replacing the medicine within the fridge, and immediate action was taken to resolve this. This was a known issue that had been raised previously in a provider performance meeting in July 2016. We also found that creams that were in people's bedrooms had not been dated on opening and therefore the expiry date of the cream could not be determined.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

When we addressed these concerns with the manager, they explained that a new medicines storage facility was in the process of being developed within the service. This would provide more storage space and better ventilation. They acknowledged the concerns we raised around fridge temperatures and opening dates on creams, and told us they would take action to resolve these issues quickly.

There were individual risk assessments in place in case of emergencies and a personal emergency evacuation plan (PEEP) was being created for each person. The environment was regularly audited for safety and the service employed a dedicated maintenance staff to carry out the appropriate checks. We saw that fire safety checks, gas safety certificates and PAT (portable appliance safety) checks were completed regularly. There was a business contingency plan in place in case of any emergency or significant event that might affect the running of the service. During the inspection we found that the home was mainly clean and in a good state of repair. However some of the bathrooms were in need of repair work to seal the gap between the floor and walls around toilets sinks and baths. There was visible dust on skirting boards and pipes which could have posed an infection control risk. The domestic staff worked to a clear cleaning schedule and we noted that staff observed good infection control practice while delivering care. We did note malodours in some parts of the home, but found that these were quickly resolved.

People and their relatives told us that they did feel safe at the service. One person said, "I do feel safe here and I don't worry about my safety." Another person told us, "I do feel safe and I never complain." The staff we spoke with understood the ways in which they could report concerns to safeguard people from risk of avoidable harm. One member of staff said, "We work to the care plans which are much better now than last time you were here- there's a lot more detail and we talk about risk assessments more in meetings." Another member of staff told us, "I have completed all my training and would report any [safeguarding] concerns immediately." We saw that accidents and incidents in the service had been recorded and remedial actions were listed to reduce the risk of recurrence.

Staff were recruited safely to work in the service. We looked at the staff records for two members of staff recruited since our last inspection and found that two references had been sought from each person's previous employers before they commenced employment. Staff were asked to fill out healthcare questionnaires and complete a DBS (Disclosure and Barring Service) check. DBS is a way for employers to make safer recruitment decisions and monitor whether staff have any prior convictions on their record.

Requires Improvement

Is the service effective?

Our findings

During our last inspection we found that the environment was not always dementia-friendly. Staff did not always have a full understanding of the Mental Capacity Act (2005) or Deprivation of liberty safeguards. Consent and capacity was not always appropriately evidenced in people's files.

Staff's understanding of the Mental Capacity Act 2005 had improved and we noted that almost 80% of the staff team had now received training to help them to understand how it was applied in practice. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

For people who were subject to a deprivation of their liberty, we found that appropriate applications had been made and were accompanied by the relevant assessment of capacity. Best interest decisions had been made where necessary. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). However people's care plans made several references to people having a deprivation of liberty authorisation in place, but it was not always clear why this information was relevant to that aspect of the person's care. For two people we noted that their deprivation of liberty authorisations were no longer active and that the care plan therefore contained misleading information in relation to what this meant for the person's care.

In most of the care plans, we noted that people had signed to consent to their care and support being provided by the service. There was now more detailed information available regarding the decision-making process and the level of support people needed to make key decisions. The staff were observed asking people for consent prior to delivering care and explaining to them what they were doing. Consent had been discussed in team meetings to remind the staff of the importance of evidencing consent through daily notes.

Prior to the inspection, we had received concerns regarding the competencies of nursing staff and the high use of agency nurses to cover vacancies. The manager told us, "We have a new nurse that's just started and another one starting next week. That means we're up to the right amount and can reduce the amount of agency nurses we use. We do use the same agencies and the same nursing staff." Since our previous inspection, two nurses had left the service which meant that shortfalls had to be covered and challenges in recruitment meant this had taken some time. We did note a high use of agency nurses on the service rotas, but saw that the same nursing staff were routinely used. There was a clear nursing induction programme in place and new agency nurses had to complete an induction shift prior to working in the home. The nursing staff received a variety of training to help them to carry out their roles effectively, but were not yet being supported with their revalidation with the NMC (nursing and midwifery council). The deputy manager told us the provider was planning to begin this process next year.

People told us their healthcare needs were met. One person said, "If I feel poorly they are quick to do something about it, they'll call a doctor out to see me." People had information in their care plans relating to their healthcare needs, which was regularly updated and reflective of their changing conditions. We saw evidence that appropriate referrals were being made to other healthcare professionals if any concerns had been identified in relation to people's health or well-being. A record was kept of any visits to the doctor, hospital or other community services.

However we found occasions upon which people's healthcare needs were not always being appropriately documented. For example a person who had been recently admitted to the home for end of life and was cared for in bed had care plans in place for most of their needs, except for continence care. The person had an indwelling urethral catheter, but no guidance was available as to how this was to be managed, such as how often the catheter needed to be changed. This could mean that they could suffer from infection or urinary retention if the care provided was not effective. A Waterlow risk assessment had been completed incorrectly in regard to the person's age and this therefore affected the total score and indicated that they were at lower risk of developing pressure ulcers. Another person had a weight loss of 8kgs over six months. This was not documented in the nutrition care plan and therefore no action had been taken. Although the person had a high BMI, the weight loss still needed to be recognised and acted upon if necessary.

People had enough to eat and drink and told us they had a choice of food. One person said, "The food is nice, they had a change of cook recently, but I would say the food has improved on the whole." Another person said, "The food is good and yes there are choices for lunch." We observed the chef asking people what they preferred for their lunch and people being offered drinks and snacks throughout the day. People's dietary needs were listed in their care plans and the kitchen staff had a list of the requirements for each of them. However one relative did raise concerns regarding the times that lunch was being served. They said, "Dinner is getting later as they can't serve the food till all the care is done which means it's more 1pm before it is served, not that it makes a difference, but it just shows the pressure they are under here." We did note that lunch was not served in the communal lounge until just after one o'clock, but people appeared to enjoy their meals.

The people we spoke with told us that their regular care staff seemed to have the correct training to carry out their duties effectively. One person said, "I believe they have the skills to meet my needs and as I am bed bound, they do pop in to see if I am okay." A relative told us, "Staff know my [relative]'s needs."

The staff we spoke with told us they received training which enabled them to carry out their duties effectively. One member of staff said, "The training is good and the new manager is pretty hot on making sure that we complete it. We get reminded if we're overdue and told we can't pick up any more shifts." The manager provided us with the training matrix for the service which showed that staff received training in a variety of areas appropriate to their role. This included moving and handling, safeguarding, infection control, health and safety and food hygiene. While most of the training was computer-based, there was practical training for moving people. Staff attended regular update training to refresh and update their knowledge.

Staff told us they had been recently supervised. One member of staff said, "I didn't have one for a while, but we've all had them recently. There's a lot to catch up on but I think the plan in future is to have them every six weeks." We saw a supervision matrix which showed that most of the staff team had been supervised in the last month, but had not received regular supervision prior to this. We noted that one member of staff had received no formal supervision since January 2016. The staff we spoke with told us this was due to changes in management and staffing pressures making it difficult to find appropriate time. The manager told us that they intended to make supervision and appraisals more regular in future and that these had

fallen behind due to changes in management.

Requires Improvement

Is the service caring?

Our findings

Some of the people and relatives were spoke with were complimentary about the quality of care being provided and the kind nature of the regular care staff. However most expressed concern that the frequent use of agency staff meant that they did not receive consistent care. Several people told us that staff were rushed and pressured and that the change in staff's working hours had been difficult.

One person said, "The regular staff are good at caring, but I don't like the agency. At the weekends we see a lot of agency, night times as well. Staff struggle here and it's not fair to put people under pressure." Another person told us, "The carers are good and help me all they can, they are kind and respectful." A third person said, "Yes the staff are good at care as they try their best, they all seem so rushed at times, but they are polite and kind." A relative said, "I think the carers are good though when [person] first came here they utilised a lot of agency staff. Regular staff get upset as agency get more paid than they do and don't know the people."

We discussed the impact on the quality of people's care of the use of agency staff with the manager. They explained that through recruitment of more staff, they were trying to address the staffing shortfalls and reduce the use of agency staff wherever possible. The use of agency staff had reduced in the two months prior to our inspection. Many staff had resigned since our previous inspection and the manager attributed this to a change in "the culture of the service and working hours", which had not suited some staff. While steps were being taken to address the issue, it was apparent during our conversations that the lack of consistency and competence of staff was impacting upon the overall standard of care being provided.

During our observations around the service, we found that staff were kind, respectful and considerate when delivering care to people. We noted that when staff had an opportunity to engage with people they were upbeat, positive and friendly in their approach. We observed people laughing and joking with staff, saying morning prayers and being called by their preferred names. One member of staff told us, "I love the [people] here, they're like a big family to me now."

While we found that the attitude of staff was positive, there were some aspects of the service which did not always promote a caring approach. Because of the layout of the building and the staffing ratios, people's choices and preferences were not always observed. We entered the service at 8:00am and found all of the people still in bed, some having just had breakfast. The majority of the morning was spent completing medicine rounds, serving breakfast and undertaking personal care. The first person did not leave their room to come to the communal lounge until 9:30am, and people were still being supported with their personal care until 10:30am. At 9:30 we were told that only sixteen people had eaten breakfast. This was because most people ate breakfast in their bedrooms and some required support, which meant at that time, staff were unable to support others. Lunch was then served at around 1:00pm but one person expressed concern that this was getting "later and later". We found that while staff were able to carry out care in a compassionate and thoughtful manner, there was a task-focused culture which impacted upon people's confidence and willingness to ask for help. Two people we spoke with told us they did not want to "trouble the staff" and we had to encourage one person to use their call bell to ask for help.

We received mixed responses when we asked if people felt treated with dignity and respect. While most people reported that they were respected by their regular staff, others had raised concerns about agency staff. One person said, "I can't fault the regular staff they work hard, but the agency staff are poor. I complained about two male agency staff as they were so rough with me, but the regular staff treat me with respect and dignity." Another person said, "The carers are good and help me all they can, they are kind and respectful." We noted that this issue had been raised during a key worker meeting and the manager told us that they no longer used the agency staff in question.

We observed that people were being treated with respect by staff and that staff were aware of ways to promote people's privacy. One member of staff said, "I always knock before I go in even though [person] doesn't have capacity. It's just good manners."

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in June 2016, we found that care plans were not person-centred and there was no evidence of involvement from the person or their relatives. During this inspection we found that the standard of care plans had improved significantly and were now more person-centred, detailed and reflective of the person's needs. However most of the people and relatives we spoke with still did not feel involved in the care planning process. One person said, "I haven't seen a care plan, there's only the notes in my room." However a relative did say, "They do call me about the care plan and I've been asked to come to reviews."

When people first came to the service, an initial assessment of need was completed which determined the level of support they required with different aspects of their care. These assessments were then used to develop a more comprehensive care plan. In each plan we saw an overview of the person's most essential 'need to know' information which assisted staff to understand their priority care and support needs. We saw that in some plans, work had been undertaken with the person and their family to ascertain their background, life history and personality. This included places they had worked, their family life and what was important to them. The manager was able to show us two care plans which had recently been updated with more person-centred information. We found that the greater level of detail about the person themselves removed the focus from tasks and duties, and gave the staff a greater insight into their personality and character.

The care plans were divided into sections which were personalised according to need. For example we noted that people living with dementia had a specific care plan for their mental health needs and emotional support. People's routines, interests and hobbies were also included, as well as their level of engagement and how they could be supported with certain tasks. We noted that people had been consulted on their choices in relation to times they preferred to wake up and go to bed, and the gender of the care staff that provided their care.

Care plans were subject to regular reviews and we found that in all of the care plans we looked at the information was up to date and reflective of the person's current level of need. Each part of the care plan was reviewed each month and updated with any changes. For each of the care plans we looked at, we visited the person to check whether it was being followed in practice. We found in each case that it was, and the quality of recording had improved overall. Daily logs were now completed to account for how often people were checked and to keep a record of the care delivered each time.

We asked people about the activities available in the home. One person said, "There's not much going on. I prefer to stay in my room to be honest." Another person said, "The old activity co-ordinator left, there's not always a lot of time for things as the staff are busy. They try their best." The activity co-ordinator had left the service three months prior to our inspection and had not been replaced. The manager explained that the expectation was for the care staff to engage people in activities during the afternoon. We noted that people had taken part in bingo, played card games and other games. There was an activity taking place in the afternoon on the day of our visit. However during the morning there was very little simulation available for

people. A volunteer did provide some company for some people, but the lack of a dedicated activity co-ordinator meant that activities were taking place at prescribed times and were dependent on staff being available to facilitate them. The high levels of need for many of the people using the service meant that it was challenging to engage everybody, however we did find the atmosphere in the home was dull and that people were sat in silence or asleep for prolonged periods during the day.

People told us they knew how to make a complaint and had been provided with information on how to complain if necessary. One person said, "I have complained about [issue] and [relative] is taking it up with the Local Authority too." Another relative told us, "I am here every day and would soon complain if I felt I had to." We looked through the log of complaints received by the service and noted that none had been received since the last inspection. While no complaints had been formally logged, we were aware that some people had verbally raised concerns about the quality of their care. Not keeping a record of these meant that the service could not always evidence how they were dealing with people's concerns. However we did see that some issues raised in key worker meetings with people had been addressed in staff meetings so that they could learn from these and make improvements.

Requires Improvement

Is the service well-led?

Our findings

A new manager had started in the service in August 2016 following the departure of the previous registered manager and deputy manager. The manager had not yet submitted an application to register with the Care Quality Commission, but planned to do so imminently. We asked about the progress of their registration application and the manager said, "The [provider] wanted to see how it went first, I'll be applying immediately."

We requested an action plan from the provider following our previous inspection to outline the improvements they planned to make. This was due by the 14 July 2016, but was never received by the Commission.

The manager was able to tell us about how they had addressed some of the issues highlighted in the previous inspection, improvements they had made since they started and the improvements they planned to make in the future. For example we were shown to one room which was being transformed to a hairdressing salon, nail bar and massage parlour. Plans had been drawn up to create a new medicines storage facility. The manager was aware of their responsibility to make notifications to the Care Quality Commission and demonstrated good values and working practices. They said, "I always wanted to help people and I feel that here I can really make a difference."

We received mixed responses when we asked about the effect of the change of management upon the service. One person said, "I was alarmed when both managers left and staff left, this new manager doesn't seem to listen to anybody." Another person told us, "I don't know who the manager is, but I do like [deputy manager] they are a great help." A third person said, "I see the manager once a week, but today I see they are about more because you (CQC) are in." A relative told us, "I think the new manager is approachable, but sometimes there are too many changes to soon. I think if you look after your staff you won't have problems."

The staff we spoke with felt that the change had been challenging, but that the manager was approachable and adapting to the role. One member of staff said, "The new manager is positive and she is trying to sort things out, I love my job here and find it very rewarding." Another member of staff told us, "I think the manager is trying her best as she has a lot to sort out. Things have been very difficult here at times."

The manager carried out a series of audits to identify improvements that needed to be made across the service. This included audits of care plans, medicines, health and safety and staff files. The home was supported by a quality assurance manager who visited the service weekly and set action plans for the manager. However the service had been rated 'requires improvement' following a local authority contract monitoring visit in November 2016 and had been subject to on-going provider performance concerns since March 2016. Many of the issues such as staffing, supervision and mental capacity had been on-going since then and improvements were not always being made within acceptable timeframes. While there had been mitigating factors such as changes in the management team and staffing, this meant that the service were not addressing persistent issues or taking remedial action to resolve them.

When we asked people how they were able to contribute their views, they told us there were no residents or relatives' meetings held at the service. However the named nurse for each person held key worker meetings where people were asked for their feedback. While these were being completed and asked people for their views, it was not always clear how feedback from these was being acted upon. For example we noted that multiple people had raised the issue of inconsistent staffing and overuse of agency staff. However nothing had been recorded in 'outcomes' for the report and therefore the actions taken to resolve the issues were not being communicated to people. The manager had sent questionnaires to ask people and relatives for their feedback, but the results had not been collated.

The staff we spoke with told us they had the opportunity to contribute to the development of the service through team meetings. One member of staff said, "We are having more meetings now and we're getting to understand the new manager's expectations and how [they] want us to work." The manager held team meetings for the care staff and nursing staff, and we saw evidence within these that issues such as safeguarding, medicines, conduct and training had been discussed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The storage arrangements for medicines were not always safe.