

Bestcare UK Limited

Saxondale Nursing 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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection took place on the 17 November 2016 and was unannounced. A further two days of inspection took place on the 18 and 22 November 2016, and was announced. The service was last inspected in June 2015 and was meeting the regulations we inspected at that time.

Saxondale nursing home is registered to provide care for up to 36 older people with a diagnosis of dementia or mental health needs. There were 36 people living there at the time of our inspection.

It is a condition of registration with the Care Quality Commission that the service has a registered manager in place. 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. The registered manager had left the service and the provider had put interim management arrangements in place to support the operations and on-going improvement of the service. How?

During this inspection we found 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.

People were not always being protected from the risks associated with medicines. We found there were shortfalls in the ordering, administration and disposal of people's medicines that could result in mishandling or error. We found some people's medicines were not managed safely, so they were not protected against the risks associated with the unsafe use and management of medicines.

People told us they felt safe living in the home and relatives we spoke with told us they thought their family members were safe.

People were not being protected by the home's recruitment processes. The registered person had not ensured a robust recruitment process had been followed or recorded for all staff.

There were sufficient staff, however a significant number of staff needed to update their training to ensure they had the appropriate experience, training and skills to meet people's needs.

People on each unit received a balanced and nutritious diet, including those people on the general nursing care unit who needed their meals pureed or softened. However, people's dietary and fluid intake was not being monitored effectively. This left people at risk of poor nutrition or hydration.

People were not always being protected from poor quality care through the processes for audits and quality assurance. Some of the concerns we identified on this inspection had been identified in quality assessments undertaken by the provider, but actions had not been completed to rectify them. Others had not been identified. Some audit systems had been used effectively to improve people's care, for example in reducing the risk of falls.

People told us the covering manager was accessible and approachable. Efforts were being made to increase opportunities for people to give their feedback about the home and the quality of their experience.

We found infection control was not being managed appropriately. This meant people were at increased risk of contracting an infection.

The systems for staff supervision and appraisal were not being used consistently or effectively to support staff development and to improve their skills.

People's dietary and fluid intake was not being monitored effectively. This left people at risk of poor nutrition or hydration.

The physical environment throughout the home did not always reflect best practice in dementia care. The communal areas were tired and in need of decoration and throughout the inspection there was an unpleasant malodour in the communal areas.

We found care plans and risk assessments were not properly completed. People were not always supported to maintain a healthy diet. However, people identified as high risk of malnutrition were not weighed and checked at regular intervals.

On the second day of our inspection the acting manager was actively addressing the issues we found however it was too early to see if these improvements would be sustained.

The number of shortfalls we found indicated quality assurance and auditing processes had been ineffective. There was evidence of limited monitoring and support from the registered provider to ensure the covering manager was achieving the required standards in the day to day running of the home. Checks on systems and practices had been completed by the acting manager but there were a number of matters that needed immediate attention. This meant the registered provider had not identified risks to make sure the service ran smoothly.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.
People told us they felt "safe". Relatives told us they felt their family member was in a safe place.
People were not being protected by the home's staff recruitment processes.
People were not protected by the homes systems for the management of medicines.

Requires Improvement ●

Is the service effective?

The service was not always effective.
The service was working to the principles of the Mental Capacity Act
Systems for staff supervision and appraisal were not effectively or consistently used to support staff to develop and progress their skills.
People received food that was nutritious and well presented.
Peoples food and fluid intake was not being monitored well enough to ensure people
received the nutrition and hydration they needed.

Requires Improvement ●

Is the service caring?

The service was caring.
People and relatives made positive comments about the staff and told us they were treated with dignity and respect. The staff were described as friendly and approachable.
During the inspection we observed staff giving care and assistance to people. They were respectful and treated people in a caring and supportive way.
Staff enjoyed working at the service. They knew people well and were able to describe people's individual likes and dislikes and their personal care

Good ●

Is the service responsive?

The service was not always responsive.
There was an effective system in place within the service to identify, receive, record, handle and respond to any complaints that may be made. However the complaints policy needed

Requires Improvement ●

updating.
Care plans were not always responsive for people who were needing end of life care or who had specific health conditions. Relatives told us the staff at all levels were approachable and would respond to any questions they had about their relatives care and treatment

Is the service well-led?

The service was not always well-led
The service did not have a registered manager in place
The service did not have a robust quality assurance system in place to identify the issues we found during our inspection and to make the necessary improvements.
People found the acting manager supportive and approachable.

Inadequate ●

Saxondale 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.

The inspection took place on the 17 November 2016 and was unannounced. A further two days of inspection took place on the 18 and 22 November 2016, and was announced. The inspection team consisted of one adult social care inspector. Due to concerns around the safe management of medicines and infection control the second and third day of inspection the inspection was supported by a contract and quality compliance officer and the designated Nurse from Safeguarding Adults and Patient Experience NHS Barnsley Clinical Commissioning Group.

During the inspection we carried out observations in all public areas of the home and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime meal period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. This helped to inform us what areas we would focus on as part of our inspection. The registered provider had not 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 contacted the commissioners of the relevant local authorities who worked with the service to gain their views of the care provided by Saxondale Nursing Home.

During the inspection we spoke with five people who used the service and five relatives. Some people we spoke with could not give us a verbal account of their experience. We therefore observed their care and support throughout our visit and we spoke with relatives who were visiting. We also spoke with an external professional who was visiting the service. We looked at six care plans, medicine administration records (MARs) and handover sheets. We spoke with five members of staff, including the acting manager, care staff and housekeeping staff. We looked at five staff files, which included recruitment records, as well as other records involved in running the service.

Is the service safe?

Our findings

People we spoke with told us how they viewed the care they received and if they felt safe. One person told us "I feel safe here, I'm happy here." Relatives told us "The staff are really good here, they make sure people are safe."

We looked at how the service protected people from abuse. Policies and procedures were in place to help protect people from abuse. Staff had access to a safeguarding policy. This set out the types of abuse that can occur in care settings and guidance for staff on how it should be reported. Staff were able to describe how they protected people from possible abuse and said they knew how to report any concerns they had. During the inspection we found a strong mal odour in the foyer, throughout the communal areas of the home, as well as individual bedrooms. We found the doors and walls were dirty and sticky and in poor decorative order. Carpets on corridors were stained and paint work was chipped on skirting boards and doors. One relative told us "The carpets are disgusting here; they are a danger for the elderly." We saw that seating was worn, heavily soiled and badly stained. Attempts to clean the furniture had been made but with little result. The condition of the furniture posed a risk to effective infection control procedures. We looked around the environment and randomly selected bedrooms to look in and found that bedding was worn and tired and in need of replacement. On the day of the inspection there was one cleaner working that was in the process of deep cleaning one of the carpets in the bedroom. We fed our observations back to the acting manager. They told us the provider was aware of this and they were in the process putting together a building improvement plan.

These matters are a breach of Regulation 12 (1) and (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not detected or controlled the risks of the spread of infection

We looked at medicine administration procedures in the home. Medicines were administered to people by registered nurses. We looked at two medicine audits undertaken by management for the previous three months. Some of the issues initially highlighted included stock control, gaps in medicine administration records (MARs) completed by agency staff, and that not all care staff were fully trained in the administration of medicines by the pharmacy used by Saxondale. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. The acting manager told us they had identified significant concerns that the electronic system they were using for medicines was not functioning properly. The acting manager told us they did not have confidence in the system they were using for medicines management. In view of this the acting manager escalated their concerns with the registered provider and recently reverted to a manual recording system. We carried out a random sample of six MAR sheets. We found multiple errors in counting; There were issues with the records kept and the numbers which were in stock did not match as there was less in stock than records indicated there should have been. For example there should have been 15 tablets in one person's stock of medicine and there were only 11, in another person's stock of medicine there should have been four tablets but there were six tablets left. All medicines had been signed for on the MAR sheets so we were unable to establish if people had been given their medicine safely.

Medicines were stored in a clean and secure treatment room. A lockable medicine trolley was used during medicine rounds. Where appropriate, medicines were stored in a medicines fridge and the temperature was monitored to ensure they were within safe ranges. The temperature of the treatment room was also

monitored on a daily basis.

We found where people had PRN medicines (PRN medicines are given as and when required) prescribed there were several concerns about how this was managed. We found that people did not always have a "protocol" in place. The protocol is to guide staff on how to administer those medicines safely and consistently. We saw that some people's protocols needed more details. For example, how the person communicated they were in pain, which could be for example by facial expression or rubbing the area where they experienced pain. We shared this information with the nurse; they could describe how individuals expressed they were in pain and this needed to be included in the person's protocol. Staff did not record what dosage of a medicine they had given where there was an option for one or two tablets, which meant there was no record of what dose the person received, it also meant the medicine stocks could not be monitored as there was no record of how many had been dispensed. We spoke with the acting manager about this who told us they were aware of the issue and had spoken to all the staff who administered medicines about the importance of keeping accurate records.

We looked at the storage of medicines which required storing in a refrigerator. We found there were two bottles of eye drops stored in the fridge, there was another bottle of eye drops which showed it had been dispensed in April 2016, this was open and had been used. However here was no date recorded when the bottle had been opened. It is good practice to write the date of opening on the bottle to ensure staff know when the medicine has expired.

We reviewed the management of controlled drugs in the home. Controlled drugs are medicines which require extra security measures to be taken and very specific records to be kept of their use due to the potential for misuse of these drugs. We found the controlled drugs record book was correctly filled out. We saw that morning medicines were still being given to people at 11am. One registered nurse told us "It takes all our time administering medication, you finish the morning medication and then you have to start the lunchtime medication. "This meant that people may be at risk of not receiving their medicine in a timely manner.

We reviewed the use of topical medicines such as creams or patches. We saw that information about these was recorded on their MARs, but this did not record where the medicine was applied or in what amount. Topical MARs or body maps were not used. This meant there was no record of how much cream had been applied, or whether patches had been placed in the appropriate place. We recommend that the registered provider follows national guidance on the recording of topical medicines.

This was a breach of Regulation 12(2)(g) Safe care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We witnessed some poor practices in the administration of medicines. A number of people had been prescribed 'thickener'. 'Thickeners' are added to drinks, and sometimes food, for people who have difficulty swallowing, and they may help prevent choking. Whilst all people had the product individually dispensed we witnessed staff using two peoples prescribed 'thickener' for all the people that were identified as needing it. We checked the dispensing labels on the tins that were being used and one of the tins was out of date. We asked the registered nurse if there was guidance for staff to follow regarding which people required 'thickener'. The nurse said they had a list of people who required 'thickener' but they were unable to find it. Later in the day the acting manager gave us a list of people who required 'thickener'. We checked one persons care record and found the list did not correspond with the information in the persons care plan. This showed that there was a risk that people would not be provided with care in a safe way.

We found there was a cupboard which contained a significant amount of surplus medicine; these should have been returned to the pharmacist. We asked the acting manager about the surplus medicine. The acting manager was aware of the situation and could not offer any explanation as to how this could have happened. The acting manager said they would take immediate action to remove the surplus medicines. On the following day of the inspection the manager had taken immediate action to address these concerns. We looked at how the service managed risk. We saw a wide range of risk assessments in use in care documents including Waterlow (pressure ulcer risk assessment/ prevention policy tool), Malnutrition

Universal Screening Tool (MUST), falls, and moving and handling. However these were not always completed for people clearly identified at risk and there was evidence where actions to be taken by staff to minimise and reduce the risk, this was not always followed by staff. We saw an example where one person's risk assessment clearly stated they were at risk of malnutrition. The care plan stated that [the person] required soft diet and thickened fluids due to risk of choking. We looked at care records and they did not have a risk assessment in place giving staff clear guidance in the event of a choking episode. We looked at another person's care records and staff were instructed to 'ensure plenty of fluids'. We looked at their record of fluid intake for one day of our visit that showed 400ml intake over a day. The person was also prescribed 125g of supplement drinks three times a day (375g per day) due to their small appetite. We looked at records and they showed that on four occasions the person was only given 250g and on other days the person had in excess of 250g. The person had also fallen in the home that had resulted in an injury. We noted the person had a history of falls, however despite this there was no risk assessment for falls prevention completed. We spoke to the acting manager about our concerns and on the second day of inspection they had taken immediate action to address these concerns.

These matters are a breach of Regulation 12 (1) and (2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to the health and safety of people who used the service were not always assessed or mitigated.

Plans were in place to ensure people received the support they needed in emergency situations. Each person had a Personal Emergency Evacuation Plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. However some of the emergency evacuation plans were out of date and contained incorrect information. For example, one person's care records said the person was "not ambulant" however in the person's peep the person was recorded as being "ambulant." So what? Is there not a risk here that people may not be evacuated safely in the event of an emergency situation? We asked the acting manager how they ensured enough staff were deployed to provide safe care. The acting manager provided the dependency/staffing tool that was being used by the service. The acting manager told us they had recently increased the staffing levels within the service and were looking to introduce an additional member of staff to work from 4.00pm till 10.00pm. All the staff spoken with thought there were enough staff provided to meet and support people with their needs. From our observations during the inspection we noted staff were visible around the home. One relative told us "sometimes they are a bit short staffed."

Disclosure and Barring Service (DBS) checks were carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults

A recruitment process was in place that was designed to identify concerns or risks when employing new staff. We randomly sampled five staff files, and identified concerns with two of these. Certain risks had not been identified or addressed by the recruitment process, for example, two staff member's application process contained discrepancies in their employment history and references; there was no written evidence that these had been identified or discussed with the staff member concerned. It is a requirement of legislation that prior to employment the registered person gains satisfactory evidence of the 'staff member's conduct' in any previous employment in health or social care and other reasons why they had left. This meant the provider did not have safe recruitment processes in place.

The failure to follow a robust recruitment process is a breach of Regulation 19 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Systems were in place to monitor the safety of the building and the equipment in use within the home such as bed rails and profile beds, staff call systems, window restrictors, water quality, water temperatures, legionella, fire and electrics.

Is the service effective?

Our findings

The home's policy stated that "All staff should receive regular and appropriate supervision to improve standards, to minimise the risk of poor performance and to identify any symptoms of stress." Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually. We saw on the supervision record sheets that "Formal one-to-one supervision must take place a minimum of twice per year." However, we were unable to determine whether this had actually happened for all staff because there were only records available from August 2016. We spoke to the acting manager about the variable frequency of supervision and she agreed that this was not good enough. She told us that all staff would be getting regular supervision in line with the provider's supervision policy. The acting manager told us they planned to introduce a more pro-active approach to staff support and professional development.

This represented a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we found there was not a robust system in place to ensure staff completed all the refresher training relevant to their role. The acting manager showed us the training matrix which identified areas where staff required training, or that training needed updating. We saw there were a significant amount of mandatory training that needed to be updated; for example 13 staff still needed to complete safeguarding training and 20 staff needed to complete fire safety training. We did not, however, note any concerns with the moving and handling we observed. Staff we spoke with said, "In general I feel supported. I always speak to the manager. Any problems I address with the nurses."

The staff we spoke with told us they had completed induction training when they started working at Saxondale care home. They told us they 'shadowed' more experienced staff for about three shifts before being included on the duty rota. The members of care staff we spoke with told us they had completed e-learning in moving and handling, infection prevention and control, pressure area care, dementia, first aid, food hygiene, "In general I feel supported. I always speak to the nurse."

The Mental Capacity Act 2005 (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. People can only be deprived of their liberty to 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We reviewed the processes which were in place to assess the mental capacity of people and to ensure that consent to care was gained within the principles of the MCA. The registered provider had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and consent. We found there was evidence of capacity assessments being carried out; these were in the main in relation to day to day living. There was no clear outcome of these assessments as there was no judgement made.

Our discussions with the acting manager and staff showed they had a good understanding of the MCA and

issues relating to consent. One member of staff we spoke with said, "If I had any concerns about someone's capacity to make decisions I would talk to the manager." The acting manager showed us all the DoLS applications they had made. Those people who used the service for respite were awaiting the authorisation to come through. We saw evidence that the acting manager had made contact with the local authority to check where these applications were up to and they were still in the process of being looked at. Staff we spoke with understood about the MCA and DoLS, they explained that they would contact the local authority for support and any decisions would be made in the persons best interest.

We spoke with a registered nurse about the use of restraint which included the use of bed-rails. We saw a number of people had bed-rails in place. Scrutiny of one person's care plans demonstrated a risk assessment had been completed prior to the use of bed-rails. This was not supported through a clearly recorded 'best interests' process following an assessment of the person's capacity to consent or refuse their care and support, and then consultation with the person's authorised decision maker.

During the inspection we spent time in all areas of the home used by the people who used the service. We saw that the physical environment throughout the home did not always reflect best practice in dementia care. There was no evidence of adaptations to the environment to show good practice guidelines had been put into practice. For example, there was no evidence of contrasting colours being used to aid independence, for instance on light switches, grab rails and bathroom/bedroom doors. Corridors were all similar in colour. We saw that the environment was not dementia friendly.

The NICE guidelines "Dementia" Supporting people with dementia and their carers in health and social care 2006' states; 'Built environments should be enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment'. This meant that the environment was not suitable for people living with dementia.

People we spoke with told us they liked the food served at Saxondale. One person told us "It's very good food here. They get you what you want." One relative said told us, "One day [my relative] said I fancy a cheese toasty so they made them one. They enjoyed it that much they asked for another and staff made them one no trouble at all." Other comments from different people included, "The food is very good and there's plenty of it, and "I do look forward to my meals. I like the food they give you here."

A choice of drinks was served with lunch and a variety of cups and beakers were used to suit different needs and aid independence. We saw people were offered protection for their clothes sensitively and people who needed support with eating were given unhurried assistance.

We observed lunchtime at the service in the dining room which was where most people ate. Some people chose to eat in their rooms or the lounge. The food looked appetising and portions were generous. Staff offered people a choice of the meals and everyone had drinks available which were refilled regularly. Staff communicated with people throughout the meal time experience. People were asked if they had finished their meal before their plate was taken away.

People were supported to access external professionals to maintain and improve their health as and when required. People and their relatives said staff helped to arrange visits from clinicians whenever they were needed. One person told us, "If [our relative] needs a doctor they get them straight in."

Is the service caring?

Our findings

All of the people we spoke with were complimentary about the staff and their attitude. Comments included: "The carers are lovely people, nothing is too much trouble," and "You could not get better staff. They seem to know how to get on [my relatives] wavelength." Other comments included "We have never had any issues with any of the staff" and "All the carers are really nice, they would do anything for you. They are a lovely bunch of people."

During our inspection we observed staff speaking with people in a kind, caring and respectful manner. Visitors told us they could 'come and go' as they pleased and that they were kept informed of things that happened to their relative when they were not there. Regular care staff clearly knew residents and visitors well.

We saw that people were relaxed in the company of the care staff and that there was a friendly, respectful atmosphere. People appeared to enjoy the company of the staff working at Saxondale. We saw care interactions that were patient and kind. We saw care staff assisting people with their mobility in an unhurried way. We heard care staff asking questions and waiting patiently for answers, for instance when asking people for their choice of meal at lunch time. We heard care workers explain what they were doing before helping to move people in their wheelchairs or reclining chairs. We saw that care staff knew people's preferences for beverages.

We saw that privacy and dignity was upheld with closed bedroom doors during care interactions, and staff knocking on bedroom doors before entering. Staff would also ensure bathroom or toilet doors were closed whilst providing personal care. On the second day of our inspection we saw staff sit down next to a person and spend time talking to them. We saw their interaction was warm and respectful.

We asked the care staff to give us examples of people's likes and dislikes and were told there were people who liked to stay in their rooms to eat, or those who particularly enjoyed a sing along when these were organised.

During this inspection we found that confidential records were kept in the nurse's office. However some people's personal care information was left on top of a filing cabinet. The door to the nurse's office was unlocked and this meant that confidential information was not securely stored.

We checked people's care records that were using the service at the time of the inspection. They told staff how to support and care for people to ensure that they received care in the way they had been assessed. However, we found that some people's needs had changed and these had not been identified to ensure people's needs were met. For example one person was on end of life care. End of life care is support for people who are in the last months or years of their life. End of life care should help you to live as well as possible until you die, and to die with dignity. We checked the persons care records and found there was no end of life care plan to support the person with managing their pain and other distressing symptoms.

Is the service responsive?

Our findings

On the day of the inspection we checked to see if there was a nutritional care plan in place to advise staff and guide staff. There was a nutrition care plan however it had not been updated to reflect the person's current needs. We checked the daily nutrition and hydration records to see what nutrition and hydration had been offered and these were incomplete on the day of the inspection. We asked staff and the nursing staff and care staff gave conflicting information about the person's care for example the care staff said the person was on fluids only, however the nursing staff said that the person was still having reduced food and fluid. This meant the person was not treated with dignity and respect.

For other care records we looked at we found that people's care was reviewed regularly to ensure it met their needs. The care workers we spoke to told us that people's care needs assessments were regularly kept under review and were part of the monthly review of care plans. The registered nurses took responsibility for compiling the care records supported by the care staff.

People's care records provided a sufficient guide to staff on people's current care, treatment and support needs.

We identified a lack of social stimulation; there was an activity co-ordinator who worked 30 hours per week. Although we had positive comments regarding the activities they provided one relative we spoke with told us "There isn't enough activities." The activities co-ordinator told us "We have a weekly programme of activities but it depends on what people want to do." Prior to the inspection the activities co-ordinator had organised a range of activities including a trip to Canon Hall, a weekly exercise class called Pulse, singing sessions and reminiscence session. One staff member said, "It would be lovely to have time to talk with people but we are always too busy, they love it when you sit and talk with them." On the three days of the inspection we did not observe any activities taking place.

Procedures were in place to investigate and respond to complaints. However these needed updating because they were out of date and included the previous registered manager's details. The complaints policy set out how issues would be investigated and the time frame for doing so. We looked the complaints and compliments log for the home. We saw complaints had been responded to appropriately and actions taken to address concerns. During the last three months they had received four complaints in total. Two people had complained because they were not happy with clothes going missing from the laundry and they had told care workers about it. However these had been resolved by the acting manager. The other two complaints were about offensive smells in the lounge and hallway and the acting manager was discussing this with the registered provider.

People who used the service were not able to tell us about raising concerns due to cognitive or communication difficulties and complex needs. The relatives we spoke with said they would be comfortable raising issues and concerns with any of the staff. The acting manager said if people were not happy with any aspect of the service they could talk to her face to face and she would deal with it straight away.

Is the service well-led?

Our findings

On the day of the inspection there was no registered manager in place. 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 an acting manager in place who had only taken up their post three months before this inspection. They had submitted a notification to say the service would be operating without a registered manager. The acting manager was awaiting support from the registered provider before they submitted an application to CQC to be the registered manager.

During the inspection we found numerous concerns which we needed to speak to the registered provider or the nominated individual about. We tried to contact the nominated individual and we were told they had left the service. It is a requirement of CQC that All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe

Staff told us the acting manager was supportive and included them in the running of the service. One member of staff told us, "The acting manager has been brilliant, but there's a lot of resistance." Another staff member told us, "[Name of the acting manager] is fabulous, my role has changed a lot but [Name of the acting manager] is supporting us." People and their relatives spoke positively about the acting manager, one person told us, "The atmosphere has changed [Name of the acting manager] seems to have brought some home comforts, just things like cushion and brightening the place up."

Whilst care records demonstrated that some accidents had been reported there was a lack of effective systems to ensure there was managerial oversight of accidents occurring at the home. Whilst the manager was aware of this problem, effective processes had not been put in place to ensure that this took place. For example the audit of accidents had not been completed since 17 September 2016. This meant there was no effective process for the manager to learn from such events and put measures in place to try and ensure they were less likely to happen again.

Where there was evidence of shortfalls in the safety of people who used the service the acting manager was actively trying to address these concerns however there had not been sufficient time to effectively address the changes in care that were needed. We could not be confident that the management of incidents, accidents, pressure ulcers, nutritional monitoring and safeguarding was effective. Whilst care records demonstrated that some accidents had been reported there was a lack of effective systems to ensure there was managerial oversight of accidents occurring at the home.

We found that the governance systems in practice were not robust enough to enable the registered person to monitor and address quality issues or address risk. We identified concerns in relation to risk assessments and risk management, management of medicines, staff skills and knowledge, supervision and appraisal, recording of people's food and fluid intake, care planning and the adaptation of the environment to support people with dementia. So what?

The registered manager carried out a series of audits which were specified by the provider to assess and

monitor the quality of care that people experienced. These included audits of practice in relation to medicines, infection control, and falls care documentation, people's experience and skin integrity. Spot checks, for example of medicines management were carried out. Incidents or accidents were analysed to see if they could be prevented in future. We saw examples where staff were instructed in care plans to make sure people had plenty of fluids. We checked four fluid and food intake charts on the second day of our visit to see how accurately these had been completed. These did not reflect an actual account of nutritional or fluid intake we had observed. Failing to effectively monitor people's nutritional intake places people at increased risk of poor health.

As a result of these audits some issues had been identified and actions taken or had been planned, for example a formal accident log was in place but was not being routinely completed by staff. There had been no managerial oversight of accidents and incidents in order to identify patterns and trends and develop appropriate interventions where any risks had been identified.

This was a breach of Regulation 17) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our observations of interactions between the nurses and support workers showed they were inclusive and positive. All staff spoke of a strong commitment to providing a good quality service for people staying in the home.

The manager was aware of her obligations for submitting notifications in line with the Health and Social Care Act 2008. They confirmed that any notifications required to be forwarded to CQC had been submitted and evidence gathered prior to the inspection confirmed that a number of notifications had been received. Our inspection identified that the manager is keen to improve the service and we saw that plans were being put in place for this to happen. However, further improvements and evidence of sustained change is required.