Care Quality Commission

Ranc Care Homes Limited

Queens Court Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on the 6,7and 8 October 2015 and was unannounced.

Queens Court is registered to provide accommodation for persons who require nursing or personal care, diagnostic and screening procedures and also treatment of disease, disorder or injury. It can provide accommodation for up to 90 people some of whom maybe living with dementia. On the days of our inspection 78 people were using the service.

The service did not have a registered manager in post. 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 overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant

Summary of findings

improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During our inspection we became concerned that people were not being looked after safely. Risk assessments and care plans did not adequately show staff how to support people. People were placed at risk, because they were not receiving effective pressure area care, due to unsafe medication management and people's healthcare needs were not responded to in a timely manner and in the best way to meet their needs. Trained Nursing staff were responsible for people's healthcare and unable to respond to people's needs in part due to not having received adequate training and support from the provider. There were insufficient staff available to meet people's needs. The service did not have effective governance processes in place to monitor and improve the service.

People's needs were not always met because there were times when staff were not deployed in a way to meet these needs. Staff did not always have the appropriate recruitment checks in place, which allowed them to work with people safely.

Staff were not always supported to fulfil their role. Training had not always been effective.

People's healthcare needs were not always met in a timely manner, putting people at risk of poor healthcare outcomes.

Care plans were not individual or informative on how people would like to be supported. People were not involved in the reviewing of their care needs. People were not always supported with activities that engaged and interested them to ensure their well-being.

Staff, at times, were not attentive to people's needs and did not always treat them with dignity and respect.

The service had a complaints procedure; however, this had not always been followed through to conclusion or to people's satisfaction.

The service was not using effective quality monitoring processes to monitor its performance or to look for ways of improving the service for people.

Staff demonstrated some knowledge in Safeguarding Adults from abuse, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The manager knew to make appropriate referrals to DoLS. People were not always supported with choice over their care needs.

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?
The service was not safe.

The service did not have the correct level of staff on duty to meet people's needs. Staff did not have the appropriate checks in place.

People were at risk from not being supported safely or by having the correct equipment in place.

Medication was not always administered safely.

Inadequate

Is the service effective?
The service was not always effective

Staff did not receive the support and training they needed to fulfil their role.

People's changing health care needs were not always met promptly.

People were not always supported with making choices.

People were not always supported appropriately with nutrition and hydration.

Inadequate

Is the service caring?
The service was not caring

Staff did not always treat people with dignity and respect. For example when they were supporting people with eating and drinking.

We saw some kind and caring interactions and people made positive comments about staff.

Inadequate

Is the service responsive?
The service was not always responsive.

People did not always receive care and treatment which reflected their individual needs and preferences.

People were not supported with individual activities to maintain their well-being.

The service did not always follow its complaint procedure to people's satisfaction.

Requires improvement

Is the service well-led?
The service was not well led

Staff did not feel supported and valued at the service.

The manager did not have effective quality monitoring processes in place.

Inadequate

Queens Court 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 6, 7 and 8 October 2015 and was unannounced.

The inspection team consisted of four inspectors. We also had a specialist advisor for tissue viability. A specialist advisor for end of life care and an expert by experience. An expert by experience is a person is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, 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 previous reports and notifications that are held on the CQC database. Notifications are important events that the service has to let the CQC know about by law. We also reviewed safeguarding alerts and information received from a local authority.

We spent time observing care and used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experiences of people who were unable to talk to us, due to their complex health needs.

During our inspection we spoke with 24 people and 13 relatives, we also spoke with the previous regional manager, the current regional manager and the care manager. In addition we spoke with three nurses and 14 care staff; we also spoke with the maintenance person. We spoke with three visiting healthcare professionals. We reviewed 32 care files and monitoring charts, eight medication charts, 14 staff recruitment files and their support records, audits and policies held at the service.

Inadequate

Is the service safe?

Our findings

Some people we spoke with told us they felt safe living at the service, one person said, "You can leave the door open, there is always someone around and I feel fine, and feel safe." Another person told us, "It is alright here, I feel safe here. I have not lost anything from my room." However people and relatives expressed concerns that there were not enough staff working at the service.

People were not having their needs met in a timely manner, leaving them feeling frustrated, anxious and at times humiliated. We were told how people had to wait to have their care needs met, one person told us, "I buzzed (today) at 3pm and I am still waiting 35 mins later for the toilet, it is very humiliating." They also told us they had waited previously for over an hour for assistance. Another person told us, "We are okay but they are always short of staff and the worst times are the mornings and the evenings, sometimes the wait for the toilet is unacceptable."

Visitors we spoke with said staff are always busy, one said, "The home is quite good and I think that the carers are doing their best but there are not enough staff at certain times and things don't occur. So many residents need help like feeding and staff are trying to do their best."

Staff we spoke with also felt they did not have enough time to meet people's needs. One member of staff said, "We don't have time to do everything there is not enough staff they come and go because the workload is heavy." Staff gave examples of where people needed the support of two care workers, and they had to wait to have their needs met. On the residential unit there was three staff to support 19 people. One person when we entered the unit said to us, "Can you help me I need the toilet." They told us they had been waiting for a long time; we approached staff who said that they had been assisting another person. We noted that staff were very busy at this time assisting people with personal care, breakfast and medication. Staff said they were short of staff as another care worker was needed to go out on an escort.

On one of the nursing units there were five staff to support 21 people. We noted at 12.20pm that people were still being assisted with their morning personal care needs. Many people on the unit required the support of two staff members for all care and support needs. Throughout the morning we heard people calling out for help at different times, one person was calling out continuously for support, however staff were only able to offer brief moments of reassurance, that did not lessen the persons anxiety.

We noted throughout the inspection that staff were very task driven with very little interaction or engagement with people. We saw on the dementia unit staff walking past people without acknowledging or engaging with people. One person was sat in a wheelchair asleep when a care worker walked past them and left their breakfast for them in their room. There was no attempt to talk to them or to wake them. On another occasion we saw people left unattended for 15 minutes in the lounge, when staff left the area. We noted in care plans that some of people should not be left unsupervised due to risk of falls or agitation. This meant that when staff were not available in the lounge, people were placed at greater risk of injury as staff would not be available to intervene should a problem occur. In addition we noted in one person's care plan they should not be left unsupervised when eating due to risk of choking, however we noted on multiple occasions this person was left alone in the dining room to eat their food.

We spoke with the previous regional manager on the first day of inspection who told us people's dependency needs should be assessed monthly or before if their needs changed. This assessment was then used to calculate care hours and the amount of staff required on each unit. It was noted that no dependency levels had been completed relating to people living at the service since June. It was also noted there had been multiple admissions of more than ten people since July and people had also left the service. This meant the calculated care hours against staff numbers was out of date. We confirmed with the current regional manager that dependency levels had not been calculated for the last three months.

The service had been undergoing a period of recruitment for new staff. We were told that a number of staff had left the service but new staff had been recruited. The regional manager told us there had been a significant reduction in the use of agency staff from over 400 hours a week used at the beginning of August to less than 50 hours being used at the end of September. The service used two main agencies and tried to use the same staff for consistency. The care manager told us that the reduction in usage of agency hours was due to more permanent staff being recruited.

Inadequate

Is the service safe?

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have the information they needed to support people safely. For example we found risk assessments we not always up to date or reflected the needs of the person. We found some people moving and handling needs had changed but these were not always updated in their moving and handling assessments. We saw one person being assisted to move by two staff placing their hands underneath the person armpits to support them. This is not a recognised safe practice for supporting or moving people as there is a danger of injury to the persons shoulder. We checked the person's records which stated they needed the assistance of one member of staff to mobilise. We bought this issue to the attention of the care manager, who arranged for the assessments to be updated and for staff to use a handling belt in the future when assisting this person.

Prior to our inspection we received notifications that people at the service had developed pressure sores. At our inspection we found that the management of pressure area care was not effective. Five people were being actively treated with pressure sores at the service at the time of our inspection, whilst other people who had reduced mobility were being monitored to prevent pressure sores developing.

People were at an increased risk of pressure areas as the preventative measures in place were not being followed. For example, where it was recommended that people were repositioned two hourly, we found that this was not always recorded on their repositioning chart. This meant it was not possible to determine if they had been repositioned placing them at risk of developing pressure areas due to lack of relieve.

Some people had pressure relieving mattresses; these are filled with air and have a ripple affect so that there is a constant change of pressure. Of the nine mattresses we looked at seven had the wrong weight setting. For the mattresses to work efficiently they need to be set at the person's weight. We also found on four occasions the mattresses were set at static, this meant they were not moving the air within the mattress, which placed people at increased risk of developing pressure sores. Mattresses should only be placed in the static setting when personal care is being given and this should be no longer than 20 minutes. We addressed this issue immediately with the nurse on duty, who ensured all the mattresses were set at the right setting. The care manager told us that it is the day-to-day responsibility of the nurse on duty to check people's mattresses and ensure that these were at the correct settings, however it remains the overall responsibility of the Registered Provider of the service as per the regulations to ensure that people receive safe care and that equipment in use are used appropriately for its intended purpose.

People we spoke with said they got their medication, but could not say if it was on time or when they needed it. We reviewed medication records and saw that there were gaps with recording, mainly of topical medication. For example, where these were prescribed twice a day we could only see that these had been applied once. We also noted gaps on the recording of a person that required a pain relieving patch. We discussed this with the nurse and saw that the patch had been administered to the person but the record had not been signed. We also noted for the same person a previous patch had been left in place for three weeks when it should have been removed after a week. These patches are for pain relief and are prescribed for application once a week; the instructions are also to rotate the site of application on every occasion. This meant the person was at risk of not receiving their pain medication correctly, potential damage to their skin and that the administration of their medication had not been monitored effectively. Although this was addressed at the time the nurse could not explain how the error had occurred.

We observed another person had been prescribed eye drops every two hours however we could only find evidence on the medication chart that this was being administered five times a day. Although the nurse reassured us they were administering the drops two hourly this was not being recorded anywhere. This meant there was no system in place to ensure the person was receiving their medication correctly. This placed them at risk of not receiving their eye drops as prescribed.

We spoke with the care manager and the nurse confirmed that it was their practice to perform a gap analysis on any charts with missing signatures however we could not find any evidence of these. If the analysis was being completed it was not identifying the issues we had found.

The service had processes in place for the management of medication, however these were either ineffective or not

Inadequate

Is the service safe?

being adhered to by trained staff. On the nursing unit qualified nurses dispensed and administered the medication on the residential unit, senior care staff who had received training in medication performed this role. We noted staff were provided with a tabard to wear when doing medication stating do not disturb. This was to allow the member of staff doing the medication round to give their full attention to the task to try and minimise distractions which could lead to errors. We noted the nurse on the nursing unit chose not to wear the tabard as she said it does not work and she is still interrupted. This meant the nurses was not working in line with the provider's processes to try and reduce medication errors.

These failings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of how to report safeguarding concerns. One member of staff told us, "I would report anything to the nurse or I'd talk to the line manager." They also said "We can call CQC if we need to and there are posters downstairs for people we can call." Another member of staff told us, "I would whistle blow to the management." The service had policies and procedures for staff to follow should they wish to raise a concern; they had access to these in the staff rest room or main office.

We saw that where safeguarding concerns had been raised they had been investigated by the local authority and the staff continued to monitor people's safety.

The premises and equipment were maintained to ensure people's safety. The manager had employed a maintenance person who had been in post for the last two weeks. We spoke with the maintenance person who was in the process of conducting a full review of the service needs and was addressing urgent issues immediately. For example, ensuring wardrobes were attached to walls and not free standing on the dementia unit, as these had been identified as a risk of being pulled over. They had also done an audit of the service call bell system and were in the process of ensuring these were all working correctly, and were performing repairs where required. We saw that equipment had been serviced and had stickers on them detailing this.

The provider did have recruitment procedures in place; however the staff files we reviewed did not always contain the information required from the recruitment checks. For example, of the 14 files we found one did not contain references and four did not have any records of Disclosure and Barring checks. Following our inspection the regional manager was in the process of checking that they did hold all the relevant checks on staff. They informed us that for the staff they did not hold the relevant checks; they would complete these immediately. These checks are important to make sure people are being supported by staff who are safe to do so.

Inadequate

Is the service effective?

Our findings

Staff were not provided with the skills, support and knowledge they needed to provide effective care to people. Staff told us they received a mixture of face to face training and e-learning. Two members of staff told us that they needed to complete 12 modules of e-learning but they had not done this. It was not determined how staff embedded training into practice for example we saw some staff had failed their training but there was no explanation given from the care manager how this would be addressed. One member of staff who had just completed moving and handling training was observed carrying out an unsafe lifting technique. We asked the care manager how they checked staff were carrying out learnt techniques properly but they were unable to tell us what processes they adopted to check safe practice.

The care manager told us in addition to moving and handling training, the staff were receiving training in wound management and pressure area care and had planned for staff to receive training in palliative care at the end of October 2015. We spoke with a care home practitioner who was delivering training on pressure area care at the service. They confirmed they would be coming to the service weekly to train one or two members of staff at a time in recognising pressure areas, prevention and treatment of wounds. Staff identified to us that they also required training in other areas such as the use of syringe drivers. Staff told us that due to their lack of training with this equipment it could not be used at the service. This meant people were at risk of not receiving the correct pain relieve and care in the best prescribed way. The care manager said they were going to source training for this. Staff training needs and further development should be discussed as part of regular supervision meetings between staff and their supervisor or manager, however as supervisions were not taking place routinely the need for such training courses had not been identified.

Staff told us that they had infrequent supervisions, one said, "I think I had supervision about three or four months ago." Some staff were unclear who would give them supervision, one member of staff said they discussed any issues at the morning handover. Supervision is important for staff to discuss any issues they had around their practice or training needs and how they can add value to the service. The lack of supervision of clinical staff meant that the provider had not identified the need for specific training such as the use of syringe drivers and phlebotomy. From records we reviewed there was very little evidence of staff receiving formal supervisions or yearly appraisals.

The regional manager told us that new staff had a three day induction to the service. However, we found very little evidence of inductions being completed. One member of staff told us they had an induction for a day to go through policies and then had four hours induction on another unit before being left in charge of the unit. Another member of staff told us, "New staff go on the floor after two days and they don't really know what they're doing." The care manager told us that they intended to enrol new staff who have not had training or experience with working in care into the new Care Certificate. This is industry recognised training that provides staff with the skills and knowledge they need to support people. The care manager told us two members of staff were due to receive training in how to deliver this training to new staff, but this was yet to be implemented.

These failings were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs were not always attended to in a timely way. Staff told us that the GP attended the service weekly and if they had any issues of concern they would call the GP. However we found that staff did not always follow the instructions left by the GP and these were not always added to the care plan. For example, the GP recommended staff added a thickening agent to a person's drinks this had not been added to their care plan and when we asked staff they did not seem to be aware of this. We noted that thickening agent had not been added to their drink. We also saw that the GP had requested for blood tests to be carried out on two people which had not been completed. One had been requested a month ago and one two days previously. When we asked staff about this we were told that they had to wait for the nurse who was trained in taking blood to be available to do this. These bloods were then taken at the time of our inspection. Staff not following healthcare advice promptly was placing people at risk of poor healthcare outcomes.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

People at the service had varying levels of capacity. CQC is required by law to monitor the

operation of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards (DoLS). We were told the manager, where appropriate, had made applications under the act. Where assessments indicated a person did not have the capacity to make a particular decision, there were processes in place for others to make a decision in the person's best interests. We found that staff had not always completed this paperwork correctly, for example they did not explain how the person would be supported in their best interest. This meant staff may not always have the information they needed to support people when making decisions.

People's dining experience was varied across the service. One person told us, "The pasta, potatoes and meat are all good and tea time I have soup and toast and at 8.30 tea and biscuits." Another person said, "Food is reasonably nice, I like the yogurts for desserts, they always have them." We observed a number of meal times and saw people had a varied choice at each meal time, we noted if people did not like the choices available they could ask for an alternative. The majority of people ate in their rooms on the nursing units, with only one or two people eating in the dining rooms. In contrast on the other units people mostly used the dining rooms. On one unit we saw there was a pleasant atmosphere throughout a lunchtime with staff supporting people appropriately with their meals. We also observed people being given choice about what they wished to eat and drink. In contrast on the dementia unit, we saw very little positive interactions throughout the mealtimes.

We saw from records that where appropriate people were referred to dieticians and speech and language therapist. We also saw that people had their weight monitored. Staff completed nutrition and hydration assessments on people; however no member of staff we spoke with could explain what the scores on the assessments meant, and how this impacted on the support people needed.

Inadequate

Is the service caring?

Our findings

People told us that staff were kind and caring. One person told us, "They are lovely girls, all of them, very kind but they have to work too hard." Another person pointed at a member of staff and said, "She should get a gold medal." Visitors we spoke with had positive comments to say about the staff, one said, "I have seen the staff do lots of lovely things and they have made a big difference to (person's name) life, she gets her hair done here and she walks up and down and we are relieved that she is safe."

We saw some examples of positive care being given, for example a member of staff encouraging a person to walk with them at their own pace and offering reassurance to them. A relative told us, "I am happy with the place and when I am here I can see how the carers look after the residents, the care is good and they try and calm people when they are frustrated, they look after everybody and are very patient with them." We saw examples of care workers speaking to people with warmth and kindness engaging with them at eye level to show they were important and that they were interested in what they were saying. However, we saw some examples of poor care practices for example care staff not engaging or talking with people they were supporting. We saw one care staff member standing above a person to the side of them, holding a beaker of drink which they were supporting them to drink. There was no interaction with the person or explanation of what they were doing. We also saw people being supported to eat by staff who were out pacing them and rushing their food, without any engagement or conversation with them. This is not showing people they are valued or treating them with dignity and respect.

We observed staff to be very tasked focussed throughout the inspection, one member of staff told us, "Only time we get to spend with people is when we are giving personal care." At times when staff were focussed on other things we saw when people were distressed they did not respond to their distress. This meant people were not always being supported in a caring way. However we did see at other times staff responded to people who were distressed promptly. People told us they had a keyworker, this is a named care worker who helps support their needs, one person said, "They help me with my clothes and make-up."

We spoke with one person who was anxious and shouting out, "I just want to die I can't stand it anymore." A care worker came into the room and said "Don't' die (person's name) I'm sorry I've got to go." and promptly left the room. This interaction did not reduce the person's anxiety.

We also noted that staff did not always give people choice and made decisions for them with regards to what food they would eat or if to wear protective clothing. For example people who lived on the dementia unit were not offered a choice of drinks and we observed staff handing them biscuits instead of letting them chose what they wanted. We also saw protective clothing being placed on people without consultation with them first. In addition at a meal time we observed food being placed in front of people without any explanation of what the meal consisted of or checking if the person wanted it. The serving of the meals was chaotic, for example where there were four people sitting at a table one person would be served their food, whilst the other three waited without anything to eat. On two separate occasions we saw one person take another person's meal and start eating this. On one of these occasions when the staff realised they let the person finish the meal and replaced the person's meal who it had been taken from. However on another occasion, staff took the meal from them and proceeded to support another person to eat what was left of the meal.

These were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to individual religious support should they require this, and we saw people receiving this support.

People and relatives told us that they visited at all different times without any restrictions; one relative told us they had the code to enter the service.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. People's care was not always person centred and individual to their needs. People were not always involved in the planning of their support needs.

People living at the service had care plans in place outlining what support they required. However we found these care plans to be very generic with little evidence of people's involvement. For example if a person was at risk of falls, the care plan stated support measures were, supervision and monitoring, there were no other instruction of how people should be supported or kept safe. Where people required assistance with personal care, the care plan would state requires assistance of one or two care staff. There was no instruction of what support the person required, or how the person could be supported to maintain their own independence. This meant the care workers did not have clear guidance to follow and this put the person at risk of not having their care needs met. We found that care plans were not always reviewed monthly in line with the services processes and where they had been reviewed there was no evidence that people had been consulted. One person said, "I know I have a care plan but they don't talk to me about it."

People were not always supported or encouraged to follow their own interests at the service. On the dementia unit we saw little engagement with people and a lack of activities. The unit had an activities room and two separate lounges for people to use, however we did not see these facilities utilised by people. We did note that people's bedroom doors were very individual and brightly coloured, but we saw no other signage that could aid people living with dementia. During the day we saw people were mostly left sitting in one lounge with both the television and radio playing at the same time. The noise level was not conducive for people living there, so we asked staff to address this. On another occasion we saw a visiting relative changed the radio station to one that played more age appropriate music that people may recognise.

On one of the other units a person told us they spent their time watching television, but because the remote control was lost it stayed on the same channel and would often place itself in standby mode. They told us they found this frustrating. One person told us, "I like it in here, I like it quiet and I like the peace, I do go down to the lounge and listen to the music and I have a game of cards." A member of staff told us, "We have activities in the lounge; music, bingo and stories. Once a week an activities lady comes in." People had activity support plans, however on more than one occasion we saw it recorded that people were unable to join in activities due to their 'condition'. There was no attempt to provide individualised activities to fit their needs. The service employed a full time activities person to support people with their interests however on the day of our inspection we were told they were on two weeks holiday. We could not see that cover had been provided for their leave. The regional manager told us they were in the process of employing a second activities person so that cover would be provided in the future.

The service had a complaints procedure and policy for people and relatives to follow if they wished to raise any concerns. We reviewed the complaints folder but could not always see evidence that complaints had been addressed in line with the service policies. However we did note in recent months the new manager had begun to address complaints in writing. One relative told us they had raised a verbal complaint over missing jewellery, they said that the manager had searched the person's room and laundry. However the jewellery had not been located and they were not satisfied with the manager's response, they had not carried this complaint further. We spoke with the previous regional manager about this complaint. They told us that it was their process that the complaint should have been formally logged and reported to the police. We found no evidence of this. Another person living at the service told us they referred to the laundry as 'lost and found'. We again asked the previous regional manager about their process for missing clothes items. They told us they would reimburse people for these items if they raised a complaint.

Inadequate

Is the service well-led?

Our findings

The service did not have a registered manager in post. The provider had appointed a new manager however they had not yet gone through the process to be registered. Although the service had previously had care managers in post they had not had a substantive registered manager in post since April 2014 until June 2015 when they briefly had a registered manager in post who left the same month.

The provider's systems for monitoring the quality of the service were inadequate in identifying and responding to concerns. Audits completed had not identified that pressure relieving mattresses were set at the wrong settings. The infection control audit had not identified when mattresses needed to be condemned due to contamination. Audits also did not identify inappropriate mattress were being used, for example we found foam overlay mattresses being used on top of other foam overlay mattresses for pressure area care. We identified these to the staff at the time to address.

The systems in place to monitor people's healthcare needs were inadequate. Inadequate measures were in place for the review and management of pressure area care and tools were not being used effectively to identify the risks to people's health and how staff needed to respond to this, for example, pressure care risk assessments used were incorrect in several cases and therefore were not adequate in monitoring people's risks of developing pressure areas effectively. People's health and weights were not being monitored effectively and due to lack of governance incorrect documentation were in use and documentation such as turn charts and mattress checks were either not in place or not being completed appropriately to ensure people's safety. This meant the service was not protecting people from risk relating to their safety and welfare.

Medication management and monitoring was inadequate as they did not identify the issues we identified with regards to missed signatures of topical creams and patches not being signed for when administered or removed appropriately. We also found instructions around the recording of controlled drugs confusing, as a recent audit had led to staff being told not to record the strength of controlled drugs when entered into the controlled drug recording book. The regional manager was in the process of addressing this with the pharmacy provider. The care manager told us they carried out a gap analysis of missing signatures however; we found no evidence of these being completed or being effective to address the errors and identifying means to reduce re-occurrence of these errors.

We found that there had been no home managers' report completed since June. This is an audit tool used by the provider to identify all aspects of home governance, such as logging complaints, analysing accidents and incidents, dependency levels of people and staff recruitment. If this tool had been used it may have identified that these areas were not being monitored or addressed appropriately. The regional manager told us that they were in the process of reviewing audit tools at the service for effectiveness. This meant the service did not currently have systems and processes in place to monitor the quality and safety of the regulated activity.

These failings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff all identified that there had been a number of changes in management over the previous few months. One member of staff told us, "We've had about four managers in eight months all say I'm going to make things better." Another member of staff said, "So many new managers and new rules." A relative told us, "Each home seems to reinvent itself with each new manager, this causes confusion." Another relative said, "The manager (who is away) is fantastic, she is sorting out the home for a year and has got rid of a lot of bad wood and it is taking longer to get decent staff and it will get there under her. Her hands are tied, strings are pulled in but they do a very good job."

The current regional manager told us there had been a number of senior staff recruited over the past few months, with the aim to create more structure and leadership at the service. To assist the manager there was a new care manager in post who had a nursing background to provide clinical leadership and guidance to staff. They had also appointed a night care manager who started at the time of our inspection. They had a nursing background which meant nursing leadership and supervision would be provided throughout the 24 hour period.

The manager gathered people's views on the service through meetings with people, relatives and staff. Staff told us that the manager had staff meetings every month, and a representative from each unit could attend if they were

Inadequate

Is the service well-led?

able to be released from their unit. We saw minutes of a recent staff meeting where staff were asked for ideas to improve the service, and that the manager wanted to implement an employee of the month reward. One relative told us, "We have had two meetings since the current management in place. They are difficult meetings as can get personal, always seem to be a hard line taken for the staff. We are always promised they'll be more nurses and staff but they don't materialise or if they do they disappear." The minutes from the last meeting were not available as the manager was in the process of typing these.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were insufficient staff to meet needs, staff were not provided with adequate supervisions, appraisal and training.** 18.—(1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users must be treated with dignity and respect.** **10.—(1) (2) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People were not provided with person centred care** **9.—(1) (a) (b)(c) 3(a) (b) (I)**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way for service users, people's risk were not assessed.** **12.—(1) (2) (a) (b) (c) (e) (f) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not robust quality monitoring in place. **17.—(1) (2) (a) (b) (c) (d) (i) (ii) (e) (f)**