The Orders Of St. John Care Trust

OSJCT Southfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
OSJCT Southfield is a residential care home. It can provide personal care to a total of 36 people aged 65 and over. At the time of the inspection 28 people were receiving support. People are accommodated in one adapted building.

People's experience of using this service and what we found:
People were at risk of not receiving their medicines as prescribed as good medicine practices in relation to recording were not always followed. Some action was taken during the inspection to address these shortfalls.

Risks relating to all other areas of health and environmental safety had been identified and reduced. People were protected from potential abuse and discrimination.

The home was experiencing staffing pressures due to several staffing vacancies. Although a staff recruitment drive was underway, how the staffing needs of the home were being managed in the meantime was impacting on people and staff. Opportunities for social interaction and activities for people had been limited and staff morale was low. Some action was taken during the inspection to cover necessary staff shifts.

Although the provider had quality monitoring systems in place, these had not always led to action being taken to address shortfalls identified during this inspection. We have made a recommendation about the provider's on-going quality monitoring and support arrangements.

People's care was delivered by staff who received relevant training and guidance. People had access to healthcare support and staff worked together with other agencies to facilitate timely and effective support for people.

People received help to maintain their nutritional wellbeing.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff were caring and committed to the wellbeing of those they looked after. Staff knew people well and were aware of people's preferences and wishes in relation to their protected characteristics. Policies and procedures ensured the principles of the Equality Act 2010 were met.

The Accessible Information Standards were met; people received information and were communicated with in a way which met their needs.

People were involved in planning and reviewing their care according to their preferences and individual diverse needs. Relatives and representatives were able to speak on behalf of people where appropriate. Information about people's care was kept up to date to reduce the risk of people receiving unsafe or inappropriate care.

People's end of life wishes were explored with them and a dignified and comfortable death was supported.

People had opportunities to take part in social activities, although, these at times had been curtailed when the needs of the home had taken priority.

People and their relatives had opportunities to feedback their views.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection:
The last rating for this service was Good (report published 15 November 2016).

Why we inspected:
This was a planned inspection based on the previous rating.

We have found evidence that the provider needed to make improvements to the quality of the service. Please see the 'Is the service safe?' and 'Is the service well-led?' key questions of the full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for OSJCT Southfield on our website at www.cqc.org.uk.

Follow up:
We will ask the provider for an action plan telling us how they intend to improve the key questions 'Is the service safe?' and 'Is the service well-led?' to at least 'Good'.

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.	**Requires Improvement**
Is the service effective? The service was effective.	**Good**
Is the service caring? The service was caring.	**Good**
Is the service responsive? The service was responsive.	**Good**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

OSJCT Southfield

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team:
This consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case care of elderly people.

Service and service type:
Southfield is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did before the inspection:
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and NHS healthcare professionals. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection:

We spoke with seven people who lived at Southfield. We spoke with the deputy manager, a representative of the provider (an area operations manager) and eight other staff. This included the maintenance person, activities co-ordinator, members of the day and night care teams and housekeeping team. We spoke with one healthcare professional.

We inspected five people's care files, which included care plans and risk assessments. We also reviewed repositioning charts and medicine administration records. We reviewed records relating to the management of the service which included, staff rosters, two staff recruitment files and a selection of audits.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely:

- Medicine administration records (MARs) had not always been signed, following administration of people's medicines. Accurately maintained MARs reduces people's risk of medicine errors because staff have a clear audit trail of what medicines have been administered and when. A process had been put in place to monitor people's MARs for gaps in staff signatures and a record had been kept of these gaps. At the time of the inspection, the monitoring processes in place were not effective enough to identify shortfalls identified during the inspection or to follow up gaps in staff signatures quickly enough to ensure potential medicines errors were fully avoided. The provider subsequently confirmed that where people had not received their medicines as prescribed, this had been checked with the person's GP and no harm had come to these people. The provider also confirmed that action has been taken to ensure monitoring processes were followed to identify medicine errors and address these quickly. As these actions were confirmed by the provider following the inspection we have been unable to make a judgement on their effectiveness in protecting people from risks of potential medicine errors.
- Guidance for staff was not always available when people's medicines had been prescribed to be used 'when required'. Additional best practice guidance for these medicines helps to ensure these medicines are used appropriately and safely. Action was taken at the time of the inspection to address these concerns and appropriate guidance was completed for medicines prescribed to be used 'when required'. However, it was too soon to judge whether action taken would be effective in ensuring best practice guidance is always applied.
- One person said, "I get my medications regularly each day. I don't know what they all are, but the staff make sure I get the right ones at the right times." People told us they received pain relief when needed.
- Improvements had been made to the storage of creams and ointments and the recording of when these were applied by staff. The arrangements for medicines which required closer monitoring and more secure storage met with current pharmaceutical guidance.

Staffing and recruitment:

- People's dependency levels had been reviewed and the need to increase care staff numbers by one care worker in the morning and one care worker in the afternoon had been identified. Where possible existing staff were working these additional shifts; some new care staff had been recruited, such as a senior night carer and others were still needed. One person said, "They [the staff] are always ready to help us when we need it, it makes you feel safe knowing they are there."
- There were staff vacancies across all departments, kitchen, housekeeping and care. A recruitment drive was underway to recruit more staff. A new chef had been recruited and was due to start soon. Staff had sometimes been deployed from the provider's other services to provide catering support.

•□During the inspection, existing staff in the home were being re-deployed to ensure priority areas were covered. For example, on both days of the inspection the needs of the kitchen and laundry took priority. This meant, on one day no cleaning of the home took place and, on another day, social activities for people were reduced.
•□Staff told us there were not enough staff to complete all necessary daily tasks but that these were completed as and when staff were able. This included tasks such as deeper cleaning; high/low cleaning and shampooing carpets. We observed periods of up to 20 minutes when there were no staff present in the communal areas where most people sat. At one point we went and found staff to support one person.
•□A representative of the provider explained that the correct processes for requesting additional staff support had not been followed and the home was "firefighting". During the inspection, the provider's representative gave permission for additional staff to be requested through a care agency. Although immediate action was taken to source enough staff, at this inspection, it was too soon to judge whether the actions being taken were effective in addressing the staffing pressures seen during the inspection.
•□Staff recruitment records showed that appropriate checks were completed on new staff before they worked with people to protect people from potential harm. Checks included relevant references, police check and checks on gaps in employment.

Systems and processes to safeguard people from the risk of abuse:
•□The provider's policies and procedures for safeguarding people were known to the staff. Staff had received training on how to report their concerns. Staff told us they would report concerns immediately to senior staff who then acted on this to safeguard people. Senior staff shared relevant information with other professionals and agencies to safeguard people from potential abuse and harm.

Assessing risk, safety monitoring and management:
•□Risks to people's health and safety were identified and action taken to reduce these. Risk assessments were in place giving staff information on people's risks and how to manage these.
•□Specialised equipment, such as beds which lowered to the floor, alarmed sensor mats and pressure reducing mattresses and cushions were used to reduce risks associated with falls and the development of pressure ulcers. Staff followed safe ways of working when moving people, for example, mechanical hoists were used when people were unable to move themselves and staff had received training in using this equipment.
•□People at risk of choking were assessed by a speech and language therapist and their advice was followed in relation to what kind of food and drink should be provided.
•□People on blood thinning agents were known to staff who monitored them for excessive bruising. Immediate medical support was sought for people who were on blood thinning agents and who fell. This was to reduce the increased risk to these people of internal bleeding, post fall, going un-noticed.
•□Environmental risks were identified, and action taken to reduce these. Ongoing health and safety monitoring along with servicing and maintenance arrangements, kept the environment safe for people, staff and visitors.

Preventing and controlling infection:
•□People lived in a clean environment where arrangements were also in place to protect people from the risks of infection. One person said, 'I find the whole place including my room to be very clean, they do it (clean) most days."
•□Arrangements included the safe management of laundry, the wearing of protective gloves and aprons by staff when meeting people's personal care needs, the administration of the Flu vaccine (with consent) and early detection of symptoms which may indicate an acute infection.

Learning lessons when things go wrong:

- Staff understood their responsibilities to raise concerns, record incidents and accidents and report near misses so these could be appropriately investigated.
- The provider and home managers responded to requests for information from other relevant professionals when requested, for example, from the Coroner or the local authority's safeguarding team.
- The provider operated a safety alert system which shared information about near misses, accidents and incidents throughout their services, so actions could be taken to prevent these recurring and for lessons to be learnt from these.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same and has been rated as Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
•□People's needs were assessed prior to moving into the home to ensure the staff could meet these once people moved in. This process helped staff to identify which other health and social care professionals they may need to work with, for example community nurses and pharmacists and, if specialised equipment was needed.
•□The pre-admission assessment and subsequent care delivery considered current legislation for example, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) where required, the Equality Act and other best practice guidance. Dementia care and end of life best practice care pathways were followed.

Staff support: induction, training, skills and experience:
•□The staff training record showed that staff had received training in core subjects which the provider considered necessary to provide safe care. This included fire safety, infection control, safe moving and handling, safeguarding, information governance, health and safety, life support and first aid, and the Mental Capacity Act. Updates on these subjects had to be attended.
•□All staff completed induction training which included completion of all subjects above and an awareness of the provider's policies and procedures. One member of staff confirmed they were still completing this. They also told us they had been provided with opportunities to shadow staff when they first started working in the home, so they could become familiar with people's needs and the way the home ran.
•□Some staff had also completed nationally recognised qualifications in care such as the National Vocational Qualification and Qualifications and Credit Framework so had additional knowledge in relation to care practices.
•□One member of staff had completed additional training provided by the provider, to enable them to support other staffs' practices when supporting people who lived with dementia.
•□Staff confirmed they also attended designated meetings with their managers to discuss their on-going progress, training and development needs and any other issues they may have.

Supporting people to eat and drink enough to maintain a balanced diet:
•□People were provided with a choice in what they ate and drank, for example, a cooked option was available for breakfast each day and there were two main options at lunch time including other alternatives. One person said, "We can have a small glass of wine with our lunch if we want one."
•□People's nutritional risks were identified and managed, for example, people received fortified diets and in one person's case, a prescribed calorie supplement, to help maintain their weight. People's weight was monitored and any concerns were discussed with their GP.

•□People were provided with snacks and drinks in between meals and always had a cold drink near to hand.

•□People's dietary likes and dislikes were known to the care and kitchen staff who supported people's choices around these. One person said, "The food is good and mostly the sorts of things I would enjoy."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support:
•□Staff worked with the local authority, local hospitals, GPs, community nurses and the emergency services to ensure people's needs were met.
•□A close working relationship was in place with the local authority, so people could access permanent or short-stay support from the home when needed. On one day of the inspection the deputy manager completed a pre-admission assessment on one person who required urgent support.
•□Community nursing staff visited the home regularly to support people's health needs. This included, taking blood for analysis, monitoring people's blood sugar levels and administering insulin for people with diabetes and dressing people's wounds. Staff carried out instructions given to them by visiting healthcare professionals to support people's wellbeing.
•□One visiting healthcare professional said, "The staff are good at contacting us when needed. The staff are lovely, and the residents are happy. I never come across any care issues and my instructions are definitely followed."
•□People were supported to attend healthcare appointments either within the home or externally, such as the dentist, opticians and chiropody. One person was waiting for a visit by a dentist as they had been refusing their food. As this person could not always express how they were feeling staff had wanted the person's oral health to be checked. Another person confirmed they were visited by the community nurse on a regular basis and they were waiting for a taxi to take them to a hospital appointment, which the staff had arranged. Another person was visited by two healthcare professionals who were going to refer the person to an occupational therapist to help meet their needs.

Adapting service, design, decoration to meet people's needs:
•□Adaptions had been made to the environment to meet people's needs. For example, bathrooms and toilets were fitted with additional aids and equipment to help people physically use these facilities safely.
•□People were able to personalise their bedrooms with personal belongings and pictures which many had done.
•□Areas of the home had been made 'dementia friendly' with items put on the walls for people to interact with and pictures and other familiar items promoted conversation and helped people orientate themselves.
•□A small sitting room had been decorated and filled with items which would be familiar to people who resided in the home and which helped those who lived with dementia, to feel secure and comfortable. There was a 'quiet room' for visitors to use and private conversations to take place.
•□The garden had been adapted and could be easily accessed by people in wheelchairs. It contained items of colour and interest for people with diverse needs. This was not a secured area so people who lived with dementia and who may be at risk of leaving the security of the home unsupervised, needed support to use this area safely.

Ensuring consent to care and treatment in line with law and guidance:
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.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- People were supported to make independent decisions and to have control over the care provided to them. Care was delivered in the least restrictive way, for example, if people wished to go out, but required support to do this, staff would accommodate this. Equipment such as bed rails were not used unless it was safe to do so, and people could provide consent for their use.
- Where people had been unable to provide consent to live at Southfield or for the care and treatment they required, their mental capacity had been assessed and where appropriate, a DoLS application submitted to the local authority.
- People who had authorised DoLS in place had the appropriate documents present. Conditions applied to authorised DoLS were being met.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same and has been rated as Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
•□People were treated equally and their individual protected characteristics such as age, disability, gender, race, religion or belief and sexual orientation were known to staff and respected. It was important to one person that they be able to pray so a quiet room was made available for them to do this.
•□Staff had received training and support about equality and diversity and the provider's policies and procedures supported a zero tolerance of any form of discrimination.

Supporting people to express their views and be involved in making decisions about their care:
•□People's care was delivered around their individual preferences and choices which staff were knowledgeable about. Staff had taken time to learn about what was important to people and they supported this.
•□People were positive about how they were listened to and how their choices and preferences were met by the staff. One person said, "The best thing about being here is that the care staff are all ones you can talk to, they are all so easy to talk to and they really listen as well, trying to help sort things out in the long run." Another person said, "The staff look after us very well, they try hard to accommodate us where they can."
•□People's care plans contained their choices and preferences in relation to their care and showed that people had been given opportunities to discuss these. Care records also showed that, where appropriate, people's representatives had been able to speak on their behalf and express their views about people's care.

•□One person confirmed that people's choices were respected. They also said, "I can get up and go to bed when I want. They don't come around at 8.00pm and say come on time for bed."
•□Another person described a caring culture, they said, "Those of us who can look out for the others do, we're just like a big family here."
•□A particularly caring touch was seen in the dining room. Staff had taken the time to make placemats by laminating pictures which people liked looking at and had specifically chosen. The deputy manager told us it had been "a bit of fun with people" but it also helped some people find their preferred seats.

Respecting and promoting people's privacy, dignity and independence:
•□We observed people being treated in a respectful and dignified way. For example, people were referred to by their preferred name and supported in a way which did not belittle them or cause them embarrassment.
•□People's personal care was delivered in private and conversations about people's health or care held quietly and confidentially.
•□People were given the support they needed but staff also recognised when people wanted to be

independent. We saw examples of this when staff were supporting people with their meals or when walking.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same and was rated as Good. This meant people's needs were met in a way which met people's needs and their preferences.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences:
•Care plans outlined the support people required and gave guidance to staff on how people wished their care to be delivered. Care plans were personalised, they gave information about people's personal preferences and choices including those for end of life.
•Information about people's life histories, religious beliefs, hobbies and interests was gathered from people or their representatives and incorporated into their care plans. This helped staff have more meaningful interactions with people and supported an individualised approach to care.
•People's care records showed that people's relatives, where appropriate, were kept informed about their relatives' wellbeing and involved in reviewing care plans where people were unable to engage in this process. One person said, "My family are involved with my care as much as they want to be, but if there is a problem the home will ring them." Another person said, "I've been here about [time in years] and my family are involved in my care plan."

Meeting people's communication needs:
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
•People's care plans identified people's communication needs and gave staff guidance on how to meet these. They gave detail about whether a person required hearing aids, whether they communicated verbally or for example, by facial expression only.
•Information could be provided in various formats to meet people's needs, for example, large print or audio.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them:
•The home employed an activities coordinator who supported people with activities they wished to take part in. The coordinator said, "I have a plan for activities but often the residents don't want to do that, so I will find something they will enjoy, and we do that together." Staff provided some activity support when they were able to.
•Although the coordinator kept a record of the activities they provided (care staff did not always) this did not provide a full evaluation of the benefit of the activities provided to everyone. It was therefore difficult to assess how meaningful the activities being provided were to people, although clearly, people were involved

in choosing what activity they wanted to take part in.
•□In the case of one person there were good records showing how the coordinator had tried hard to support the person with activities which were meaningful to them to try and improve their engagement in these.
•□External entertainers visited the home providing exercise, music sessions and visits by animals, which people enjoyed. One person told us how they spent their day and said, "They organise activities sometimes. Monday is exercises, and Wednesdays are music with movement; exercises really."
•□Several people kept in touch with the news by having a newspaper ordered and delivered for them.
•□People were generally positive about how they spent their day, completing word searches, reading their newspaper and watching the television. We observed the television to be on all day even when people sitting around it were asleep.
•□Despite the interruption in the activities programme, caused by the coordinator needing to cover kitchen assistant shifts, people's feedback was positive about the activities which were provided, although they said they would like more trips out.
•□Several people remained in their bedrooms either due to ill health or their personal choice. We observed the care staff to be working in a task led way, with little time have meaningful conversation with people, however, when they visited people in their bedrooms they took time to listen and interact with them.
•□The activities coordinator ensured they visited people in their bedrooms across the week. Where people wanted they sometimes provided nail care or a hand massage, read to them or just chatted with them.
•□People were clearly fond of the regular hairdresser who was an integral part of helping people to come together and socialise. People could book a hair appointment in advance or on the day, or just visit the salon to have a chat.
•□Relatives and friends were always welcomed and also seen as an integral component to people's wellbeing.

Improving care quality in response to complaints or concerns:
•□The provider's complaints policy and procedures were on display for people and visitors to the home to read. The deputy manager explained that they and other senior staff were always available to talk with if people or others had a concern. Areas of dissatisfaction were addressed immediately and addressed.
•□One person said, "If I need to complain I can but it never gets to that, we can talk to any of the staff and they will listen." People told us they felt able to speak with the deputy manager who they confirmed was highly visible each day they were in the home.

End of life care and support:
•□People's end of life wishes, and preferences were explored with them and took into consideration their individual protected characteristics. Where people were unable to engage in these conversations, where appropriate, their representatives and those close to them had opportunities to speak on their behalf.
•□Arrangements were in place to be able to support people's health needs and any spiritual or cultural preference.
•□Relatives were provided with support by staff who were experienced in supporting people and those who were close to then, at this time of a person's life.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people:

- Staff told us they did not always feel supported. The gaps in the staffing and the way this had been managed had resulted in low staff morale.
- People were aware of how the staff felt and one person said, "We have lost a lot of good staff recently" and another worried about the staff generally and said, "Everything has to be flat out working. I feel sorry for the girls [the staff] they work so hard but are always short staffed."
- Despite this people told us the care staff worked hard to ensure they met their needs and preferences whenever they could. They told us they felt cared for and part of "a big family."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- Staff were aware of their responsibilities and were committed to ensuring the home met people's needs and that the best outcomes for people were achieved. They were aware of the provider's policies and procedures and adhered to these.
- Although the staff recruitment drive had begun to fill some staff positions, others still needed filling and staff absences needed to be covered.
- The process for covering staff vacancies and absences was initially for the staff to phone all the provider's services to locate available staff. Staff told us as there was usually none available and they had limited time to continue making these calls. They told us that having to do this on a regular basis was unhelpful and at times stressful. Last minute staff absences caused additional challenges. Staff had therefore started to cover the priority shifts themselves by completing other tasks or roles within the home, other than their own. For example, covering the kitchen assistant role instead of providing activities and covering the laundry instead of the cleaning when only one member of the housekeeping staff was on duty.
- We spoke with the provider representative, present at the inspection, about how cover for staff was organised. They told us staff were leaving it too late to locate external staff to cover the required shifts. They told us gaps in catering staff, which could not be covered by staff from other services, should have been put out to agency. Staff told us they had been unaware this was an option and unaware of how to organise this. The provider representative told us where staff shifts remained uncovered they would always give permission for these shifts to be put out to an agency. They told us staff had put themselves, in a position where they were now "fire-fighting".
- At the time of the inspection the registered manager had been on leave for The circumstances was

exceptional in that the registered manager was not present during the inspection and had been on leave for three weeks and therefore was unable to contribute to the inspection process. leading up to the inspection. A care dependency tool used by the provider had identified that more care staff needed to be on duty and these additional hours needed to be covered. There were also other staff vacancies and staff absences, across all departments of the home. Shifts that were uncovered due to a staff vacancy, the need for additional care staff or planned staff absences were already known before the registered manager's leave. Whilst it is accepted that some of these staff shifts would have got gradually covered, through the existing staff picking up extra working hours or through cover being obtained from the provider's other services, it was still the case at the time of the inspection, that some of the shifts had still not been successfully covered. Permission for care shifts which still needed covering the week after the inspection had still not been given. We raised concern about how these shifts would get covered in time. Immediate permission was given for these shifts to go to agency and these were covered almost immediately.

•□There had been a lack of sufficient support and effective monitoring of the service by the provider during the registered manager's absence. For example, the additional monitoring process, implemented by the provider's representative, to address unsafe practice relating to people's medicines, had not been fully implemented. The information on this audit had not been reviewed so the process had not been effective in driving improvements immediately to ensure potential risks to people from medicine recording errors were addressed and reduced. received their medicines as prescribed. This was identified by the inspector during the inspection.

•□Despite completion of the provider's programme of quality audits by the home managers, the monthly medicine audit, completed in April 2019, had failed to identify missing guidance for medicines prescribed to be given 'when required'. This shortfall was identified by the inspector during the inspection.

•□The process for ensuring the home was suitably staffed and supported, in the absence of the registered manager, had not been effective.

•□The managers' daily walk around check, also previously introduced by the provider's representative, to ensure risks and issues needing action, such as those identified with medicines, were identified and addressed promptly, had not been completed in the three weeks leading up to the inspection. This was identified by the inspector during the inspection.

•□All of the above was fed back to the provider's representative, who took immediate steps to address these shortfalls once made aware of them.

We recommend the provider review its arrangements for the on-going quality monitoring of the service, so they can be reassured, that any actions for improvement are made in a timely manner and that the services support needs are effectively identified and addressed.

•□Information from other audits and actions for improvement arising from these were reviewed and followed up by the provider representative when they carried out their regular quality monitoring visits.

•□The provider had completed a full audit of the service in April 2019. The provider's rating for the service had been "Good" and a small number of actions were added to the on-going improvement plan for completion.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong:

•□Processes were in place by the provider to ensure the service met these responsibilities and that where necessary, people received a full explanation and an apology if things went wrong or mistakes were made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

•□The deputy manager told us they were out and about in the home most of the day engaging with people, their relatives and other visitors to the home. People told us this manager was highly visible and involved in their care. One person said, "We don't seem to see much of the manager [registered manager], but [name of deputy manager] is okay, she's always cheery and chatting."
•□Comments from staff were that the deputy manager was the person they went to if they had a problem, because they were predominantly working alongside them. Staff recognised that the registered manager's role was more office based and confirmed that they did engage with them and they could approach them when needed.
•□Residents meetings were held, the last in February 2019 where people had been able to voice their views and opinions. People told us they had suggested there should be more trips out but as, yet, none had been planned.
•□There were very few specific links with community organisations, but people did have visits from a local church and had been supported in the 2018 to visit some local areas and parks.

Continuous learning and improving care:
•□We shared our concerns relating to the quality monitoring and support of the home in the registered manager's absence with the provider representative during this inspection. They arranged for a visit to take place by the provider's lead on medicines and sent us information on the action they were starting to take to address the shortfalls we found. This was to review medicines management and provide support with further learning where needed. As this was still to be completed we cannot judge the effectiveness of this action at this inspection. The provider subsequently forwarded information to us which confirmed that an additional medicines audit had been completed on behalf of the provider. Other actions had been taken also to support staffs' learning and practice in medicines management. As this was completed after the inspection we have been unable to make a judgement on the effectiveness of these actions.

Working in partnership with others:
•□Staff worked in partnership with commissioners of care to ensure people's assessed needs were met and to help them access the support they needed.
•□They worked effectively with local primary healthcare professionals, such as GPs, community nursing teams, pharmacies to ensure people's health needs were assessed, reviewed and met.
•□Staff contacted those who could provide spiritual and pastoral support to meet people's specific diverse needs when required.