Rockley Dene Homes Limited

Candle Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection on 12 December 2016. At our last inspection in July 2016 we had concerns about people's safety. We took enforcement action and the service was placed into special measures and an urgent Notice of Decision served against the provider to restrict admissions to the home.

Candle Court is a care home providing accommodation and care for up to 93 people, some of whom had dementia, physical disabilities and mental health needs. At the time of our inspection there were 65 people living at the service.

At the time of our inspection the service had not had a registered manager in post since February 2016. 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.

At our focused inspection in February 2016 we found the provider was not meeting the legal requirements for staff training which was ineffective and staff had not received regular supervision. People who lacked capacity to make decisions about their care and treatment did not have their mental capacity assessed by staff before making a decision to administer covert medicines (medicine hidden in food). A safeguarding incident had not been reported to the Commission or the local safeguarding authority and so people may not have always been protected from the risk of abuse. We asked the provider to make improvements and we received an action plan stating how they would meet these requirements.

At our last inspection in July 2016 we saw that the provider had made some improvements since our February 2016 inspection. We found the provider failed to meet the legal requirements for reporting and acting on safeguarding incidents and responding to unexplained injuries. In addition, the provider failed to assess risks to people's safety, safely manage medicines, ensure that sufficient numbers of equipment used for transferring people were available, staffing levels were adequate to meet people's needs, care records were accurate and up to date and quality assurance systems were effective. We took enforcement action against the registered provider. We imposed a condition on the provider to prevent them from admitting any new people to Candle Court without the prior written agreement from the Care Quality Commission. The provider was placed into special measures by CQC.

At our inspection on 12 December 2016, we found that there was not enough improvement to take the provider out of special measures. CQC is now considering the appropriate regulatory response to resolve the problems we found. We saw that some improvements had been made on the issues we reported on at our July 2016 inspection. The provider had met most of the actions pertaining to medicine management in their action plan. However, we found new concerns relating to medicine administration on the ground floor. This

was confirmed by an external audit who noted more concerns about the management of medicines on the ground floor. We saw that medicine administration record (MAR) charts were not signed at the time medicines were administered and medicines were left in people's rooms for care staff who were not trained to administer medicines. This put people at risk of receiving inappropriate or unsafe care and treatment.

We noted improvements in areas such as, staff support, care records for people receiving one to one care and PRN protocols, better facilities to store and charge moving and handling equipment. Staff told us they felt more supported and felt less rushed due to an increase in staffing levels. They felt senior management was approachable and more available to talk to about any concerns they had.

However, we found gaps in risk assessments for people with epilepsy, which we saw was acted on by staff on the day of our inspection. People's individual needs were not always met by the service despite dependency levels being assessed and staffing levels increased. Records showed a high use of agency staff who often did not understand people's needs. Accident and incident were not always recorded, therefore no evidence of learning from these. There were gaps in staff training in specialist areas, such as dementia and dealing with behaviours which challenge the service. People were not always treated with dignity and respect in one unit and care not always delivered in accordance with people's plan of care.

The home was not dementia friendly and did not support people finding their way around or orientate to their surroundings.

Staff were positive about some of the changes/improvements but we saw that the leadership and management of the service was not consistent across the home. On the day of our inspection we saw that the unit lead on one floor was passionate about the way the unit ran. Activities required further improvement to ensure that people less able to participate in group activities were provided with activities to meet their needs. The environment was generally clean.

People felt staff were rushed and didn't always have the time to provide them with the care they needed because they were always busy.

We found repeated breaches relating safe management of medicines and risks, care records, person centred care, respect and dignity, staffing and quality assurance and leadership.

You can see what action we asked the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe. Although staffing levels had increased, people's individual needs were still not being met by the service. We found gaps in risk assessments for people with epilepsy. Medicines were not always managed safely

Is the service effective?

Requires Improvement

The service was not always effective. Staff understood the importance of asking people for their consent before providing care. Staff felt supported and received regular supervision. The service worked with other healthcare professionals to ensure people's needs were met. People were given choice of food from the menu, but we received mixed feedback about the quality of the food.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always treated with dignity and respect. We observed good and poor interactions between staff and people using the service.

Is the service responsive?

Requires Improvement

The service was not always responsive. People participated in activities, however, people unable to participate did not always have their needs met. People and relatives knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not always well led. People did not receive care that was well led and consistent. The service did not have a registered manager in post for almost a year. A number of management changes had an impact on the leadership and quality of care. Systems were not always effective.

Candle Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 December 2016 and was unannounced.

The inspection team consisted of three adult social care inspectors, one specialist professional advisor in dementia care, a pharmacist 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.

Prior to the inspection we reviewed information we held about the service. This included information sent to us by the provider, about the staff and the people who used the service. This included notifications received from the service and other information of concern, including safeguarding notifications.

We observed care in communal areas to help us understand the experiences of people who could not talk with us. We talked to four people using the service, 14 relatives, and 15 staff including the newly appointed deputy manager and consultant, operations director, staff nurses, unit managers, care workers and activities coordinators. We reviewed care records and risk assessments for 11 people using the service. This included care plans in relation to people receiving constant one to one care. We also reviewed training records and staff personnel information for staff and reviewed medicine administration (MAR) records.

Inadequate

Is the service safe?

Our findings

We received mixed feedback from people about living at the home. Comments ranged from, "Most of the staff are nice, but they change a few times," "They [Staff] are not bad. I think it is ok here," "Not really no, you have to wait a long time before they answer the bell," and "I don't feel safe here there is the odd resident that wonders in."

This was in contrast with most feedback received from relatives about whether they felt their relative was safe. Comments included, "Yes, I do. The staff gives [relative] 1 on 1 care and they are really good," "Yes, the staff are very attentive and very caring. The way they help [relative] makes me feel very safe. It also helps that he is very settled," and "This place makes me feel safe. The layout makes it feel like it is easier to get around."
Risk assessments were seen in care files reviewed. These were completed by a named nurse with care staff encouraged to feed back any concerns or changes in order that these could be updated. Risk assessments covered areas such as, risk of falls, choking, pressure sores and medicines. We saw that one person prescribed a blood thinning medicine had a risk assessment outlining the risks associated with this medicine and how staff should manage these. We saw evidence of positive risk taking to enable one person's independence. In consultation with the speech and language therapist the person was reintroduced to fluids that were not thickened so that the person could enjoy drinking more. We saw that where incidents had taken place the risk assessment had been updated. We saw that areas of risk to individuals were documented and shared during daily handover meetings.

However, risks of behaviours that challenged the service were not always followed in line with the risks documented. For example, two people who had been documented as hitting and biting staff did not have this monitored in line with their risk assessment. This stated that they should be monitored using the antecedent behaviour consequences (ABC) chart used to record behavioural concerns. However, this was not in place and the person's behaviour was not monitored. Staff were not aware that this was required. We informed the provider about this and they told us that they would be speaking with staff and reviewing records of incidents concerning this person. Risk assessments for people with Epilepsy were not in place. However, this had been identified as a gap as part of their audit of care files. Senior staff we spoke with understood people's needs in relation to this condition and immediate action was taken by the service when this was brought to their attention.

There was a system in place for recording and dealing with incidents. We saw that incidents were logged on a spread sheet. These included a number of falls, bruising and choking incidents. We noted that there were some gaps in information documented in the spread sheet. Although there had been some learning from incidents. We saw from daily care notes that incidents involving people receiving one-to-one care with behaviours that challenged the service did not have this recorded as an incident. The provider had not met the requirements of their action plan concerning logging and analysing incidents. Therefore the provider could not demonstrate learning from incidents had happened and people received safe care and treatment.

We noted some concerns with the medicines administration on the ground floor. Medicines were

administered from two trolleys with two nurses working together, giving medicines from each trolley. We noted that they checked the medicines together. However on occasions, the MAR was not signed immediately after the administration but later during the round and not by the nurse who had actually taken the medicines to people. We also saw that some people refused their medicines and staff planned to return later to see if they would take them. However, the medicines had already been removed from the packaging and had to be kept in a pot. This had the potential to lead to confusion especially if more than one person was affected. We also found medicines left in people's rooms with a care worker to administer them. The care worker told us they were not trained to administer medicines.

The service audited medicines internally and had an external audit from a pharmacist. We noted that some action had been taken as a result of these audits, for example removing homely remedies and purchasing a third trolley for the ground floor, but the external audit also noted more concerns on the ground floor than the first floor as was our experience.

We concluded that the above was a breach of Regulation 12 of the Health and Social Care Act 2008 Regulations (Regulated Activities) Regulation 2014.

Medicines were stored securely and appropriately including controlled drugs. Fridge temperatures were monitored to ensure they remained within safe limits. Nurses checked controlled drugs (CDs) daily and the medicines we checked were accurate. Nurses had received training in medicines management. The supplying pharmacy produced medication administration records (MAR) and we saw that new information was added and checked by two nurses. We were told that nurses worked supernumerary when the medicines were received to ensure they were checked in carefully. The MAR folder also contained front sheets for each person with photographs for identification and details about their allergies and preferences for taking medicines.

We saw that medicines had been signed for on the MAR as administered and codes used to show non administration, however some of these codes were used incorrectly. Some people were prescribed medicines to be taken when required and we saw protocols to support their use, but their MAR recorded the medicines as 'not needed' four times a day as if it had only been offered on these four occasions rather than when the person may need it. Emollients and some other creams were recorded and signed for by care workers on separate charts. Some people were prescribed medicines that had to be given in accordance with blood tests. We saw that this was done appropriately. Following an incident with these medicines, nurses told us that they always had a second check for administration now.

People who had difficulty swallowing were prescribed a thickening powder for their drinks. Instructions as to how thick to make it were transferred to the fluid sheets that care workers used to record people's drinks, so that the appropriate staff had the information. Some people had their medicines disguised in food or drink in their best interests. The information relating to these people was clearly recorded, including a mental capacity assessment, a best interest's decision and information from the pharmacist to ensure the medicines were taken safely.

We saw medicines being given to people in a caring manner. Nurses wore tabards to show that they should not be disturbed during medicines administration.

At our July 2016 inspection, we found that staffing levels were not sufficient to meet people's individual needs. At this inspection, staff reported an increase in staffing levels and said that this had helped them with their work. They felt that there was now enough staff on duty to meet people's needs. Staff told us that the use of agency staff had decreased. Comments from staff included, "We are no longer having to work extra

hours," "We now have less people needing one-to-one and we have more staff," "We have enough staff now and have time to spend with people," "We can do personal care without rushing." However, this was in contrast with our observations and feedback from people and relatives who had told us that there were not enough staff. People told us that they had waited a long time for staff to provide personal care and felt they did not always have the time to attend to their needs. People we spoke with commented, "They [staff] are never around. When they are here and not too busy it is okay," "Most of the staff are nice but they change a few times." Comments from relatives ranged from, "Not enough staff around," "They could do with some more staff," "There seem to be a lack of staff. They probably could do with one or two more," "…They always seem busy and rushing around," and "I think it is fine, they probably have enough."

On the day of our inspection we were informed by the service consultant that there were nine care staff and one nurse on duty on the first floor and 13 care staff and three nurses on the ground floor. In addition to this, people receiving one-to-one care had a staff member allocated to them. The consultant told us that there were only two agency staff on duty on the day of our visit and that they had recruited a number of permanent care staff and four nursing staff. Records showed that agency staff had been regularly used between 5 and 11 December 2016. We saw that between four and twelve agency staff had been used from two agencies. The operations director told us that they had reduced the number of agency staff who would only be used as a last resort to ensure that there were enough staff on duty to meet people's needs. Although staffing levels had been increased the manner in which staff were allocated meant that people's individual needs were not always met.

The operations director told us that they had introduced a new dependency tool which was used to assess the number of hours required based on an assessment of people's dependency levels across the service. This did not show how people's individual needs were being met by the service and we found on the day of our visit that people's needs were not always being met. One person had reported to us that they had been left for an hour on their commode. A family member told us that their relative had waited for 35 minutes to be assisted with personal care because staff were attending to another person. We saw another person walking around unkempt and they had soiled themselves. This was not noticed by staff until an inspector brought this to their attention after noting that they had been walking around in this way throughout our visit.

We concluded that the above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We saw that the provider had a safeguarding policy and procedure in place. Staff demonstrated appropriate awareness of safeguarding processes. They were able to tell us the signs and types of abuse they would look for that would indicate that people may be subject to abuse and the actions they would take. One qualified staff member who demonstrated a good understanding of safeguarding described an incident and learning from this said, "People on my floor are now safe."

We reviewed a sample of staff personnel files and found that staff had been subject to the necessary safety checks before being employed by the service. We saw that disclosure and barring service (DBS) checks, references had been checked and verified. We saw from the provider's action plan that there was on-going work to ensure that staff who had worked for the service for more than five years had their DBS rechecked. This ensured that staff were safe to work with the people they cared for.

Requires Improvement

Is the service effective?

Our findings

People with dementia did not have their needs met because the environment was unsuitable and had not incorporated best practice for caring for people with dementia. As a consequence, the environment was not dementia friendly. Long corridors, a confusing layout, grab rails and toilet seats the same colour as backgrounds made it difficult for people with dementia to orientate in their environment. There was inadequate signposting around the home which could lead to people being confused or distressed and not being able to find their way around.

Most relatives we spoke with told us that they were invited to care plan reviews and best interest meetings and asked their opinion. Comments included, "Yes there is a review once a year which I attend," "Yes, I think I've attended a few of them now," "There is a care plan review I think every year. They will call me and let me know it is happening," and "I have attended a few meetings where we talk about the best care for [relative]." However, one relative told us that they had not been involved in any reviews.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
Staff understood the importance of asking people for their permission before providing care. Some staff demonstrated a good understanding of the MCA said, "Every person is deemed to have capacity unless assessed or proven otherwise. We look at how people can retain, weigh up and communicate information," "There is a best interest meeting if someone lacks capacity," and "We must give people privacy, respect and choice." People who were able to sign care plans, had signed them, indicating consent to care and treatment. Where people were unable to sign due to their capacity relatives had signed. However, we found some care plans with no signatures. The documentation did not demonstrate that service had acted in line with the MCA where people lacked capacity to make decisions about their care.

The deputy manager told us that they had been put in charge of resubmitting and chasing up progress on all DoLS applications for the service. We saw from a 'DoLS tracker matrix' that some of these had been followed up and authorised DoLS indicated an expiry date. The deputy manager told us that she was still updating the matrix to ensure that the home had a DoLS authorisation in place for everyone who required one. We saw from an email received in December 2016 from the local authority DoLS team that 19 people had their DoLS referrals completed.

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 saw that records were kept of DoLS

information which had been authorised by the relevant local authority. Staff and records confirmed that they had received training in DoLS and the MCA.

Staff received supervision and some had received an appraisal. Staff told us that they felt supported by senior management and said that staff morale had improved since our last visit in July 2016. One senior staff member told us that they did supervision at least once a month and "supervision is a form of communication."

Staff had completed refresher training in areas such as moving and handling, infection control, dementia awareness, fire safety and food safety. Some staff had attended various workshops and external training. These covered areas such as wound care/progression, continence, diabetic solution cleaning, respect and dignity and dining room experience. Between August and November 2016, staff had received training delivered by the local authority on spotting and reporting early the deterioration of people using the service, so that they can receive the treatment they needed early. Staff told us that this training had helped them, "Training has really improved," and "We feel more equipped to do the job."

However, we saw from the training matrix that a number of staff had last completed training in dementia awareness between 2011 and 2014. Training in specialist areas such as understanding Parkinson's and behaviours that challenged the service were not included. Therefore the service could not be assured that staff were up to date with current best practice to enable them to effectively carryout their role. Staff told us that they had requested more in-depth training on dementia, specifically about the different types of dementia and long-term conditions such as diabetes. The provider had identified those staff that required refresher training using a traffic lights system to target training and identify gaps.

We received mixed feedback from people using the service about the quality of food. Whilst some people thought the food was satisfactory, others described the quality of the food as too salty and tasteless.

We observed people being provided with drinks during mealtimes, including tea, coffee, water and squash. We saw one person who liked coca cola had been given a glass of this. Another person on thickened fluids had recommendations about the amount of fluid offered. We asked people what they thought about the food and whether they had enough to eat and drink, one person told us, "Yes, plenty to eat and you can always have more. They also bring around drinks all day long." Another person said, "Yes, the food here is alright." A third person told us, "The seasoning can be off sometimes," and another told us that their relative's food was often left on the side and gets very cold.

Most relatives told us they felt their relatives received the right support. Relatives told us, "Yes, I think so. They are always checking with me to make sure [relative] is getting everything [relative] needs," "I hope so. I don't always get the time to look into [relative] support. But [relative] seems happy," "Yes, everything [relative] needs is given to [relative] right away. I think they know what they are doing," and "I think they will do whatever they can. They seem very good at helping [relative]."

People had been supported to access healthcare professionals to and we saw referrals to speech and language therapists for people with swallowing difficulties and letters regarding hospital appointments. Care records contained documentation of appointments made with other healthcare professionals, such as opticians, dentists and GPs. A health and care professional visiting at the time of our inspection told us that staff went out of their way and care staff were wonderful.

Requires Improvement

Is the service caring?

Our findings

One person told us that the home was a, "A good place…things are improving." They also said that staff were a, "Mixture of very good and very bad, some do a lot more than you ask for." Another person told us, "They [staff] are alright." A third person told us that, "The service is dreadful…and they do not understand my needs," and another said, "The way they handle us they don't treat us with respect."

We observed some good and poor interactions between staff and people who used the service. On one floor we saw that people were treated with dignity and respect. Staff nurses knocked on doors and announced themselves before entering people's rooms. We saw that some staff were caring and attentive and constantly reassured people when providing care.

However, on another floor we saw that some people were not treated with dignity and respect. We observed three interactions where staff scolded one person by loudly stating their name, once when they had soiled themselves and another two times when they attempted to help another person using the service. This person looked unkempt and left soiled and there was no attempt by staff to change the person into dry clothes. In another example, one person asked to go to the hospital and told staff they were sore. Care staff responded in a negative manner stating, "Why are you talking, what are you saying." Another staff member said to the person, "That's a request for the nurses," and then walked off. We saw one person receiving one-to-one care did not have their personal space respected. Staff shadowed and walked closely constantly. This appeared to make the person more agitated.

During a tour of the building the deputy manager told us that the service was, "All about dignity." She then asked staff to close all the doors of people's rooms left open. This showed a lack of understanding that some people might like their doors left open and some people had signs on their doors stating that they would like their door left open.

We concluded that the above was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff we spoke with knew people they cared for very well and was able to tell us about their preferences. For example, staff knew the football team that one person supported and their favourite foods. Handover between shifts was used to inform staff of any changes to people's needs. These were detailed and recorded changes to, for example, people's dietary needs, medicines, monitoring charts in place and risks in relation to eating and drinking. Staff told us that they had regular meetings with their manager and a handover meeting every day. Records reviewed confirmed this.

Relatives told us that they would recommend the service to others. Comments include, "I would recommend this place," and "Yes, I would, the staff here are fantastic." They also told us that staff were approachable, "All the time you can talk to them [staff] about anything," "If you need anything you can talk to the staff and they will stay and listen to you. They will help you in any way they can," and "Always, never had any problems."

People had access to advocacy services who visited the home weekly. On the day of our visit we saw that one person had been visited by an advocacy service.

Requires Improvement

Is the service responsive?

Our findings

We found the service was not consistently responsive to people's needs. For example, the care plan was not being followed by the service for one person who we observed walking around throughout our inspection unkempt and in soiled clothing. The person's 'hygiene and dressing' care plan states that the person prefers to wear clean and comfortable t-shirt, sweater and jogging bottoms. Their distress behaviour/agitation care plan did not mention the use of 'as required' medicine for general agitation when providing personal care. This is often being used for general agitation, but this had not been assessed. We asked senior staff how personal care was delivered to the person. They told us that they try at different times and tried to support the person. When asked why three staff were needed, as documented in the person's care plan, they were not sure. This person's needs had not been met and the service was not responsive to their individual needs. The consultant informed us that this person often refused personal care and had a history of self-neglect. Although staff recorded in daily records in some instances when the person had been refused, the monthly review of care did not reflect this.

For another person who told us that when they use the call bell staff turned off their buzzer, telling them that someone else would come and help. "It happens all the time, doesn't matter if it is day or night. I have spoken to them about it but nothing changes."

We found some care plans had recently been reviewed. Care plans showed that although personal interests and histories were present for some care records these did not show who people were and what their likes and dislikes were. People's preferences on how they wished to be supported were not included in care plans. Some evidence of improvements was seen on files that had been updated but the recordings of preferences were not consistent.

There was an activities programme and the service had recently employed an activities worker, increasing the number of activities coordinators to two for the service. There was access to a garden on the ground floor, we saw people using this during our visit, also on the first floor there was a small indoor garden which people had access to. One person told us, "I don't want to take part in any of them [activities]." Another person said, "I enjoy the music when they do that."

However, we received feedback from staff who told us that activities were poor. Those more able to participate in activities and more mobile with no behaviours that challenged the service went out. During a walk around the building we observed that other people remained in their rooms in bed for the whole day. Doors to a number of people's rooms were closed. People in these rooms were potentially isolated and did not benefit from the activities provided by the home. In one room where activities took place, we observed that this was very small, cold and bare with three chairs situated in it. The television was on loud and the music playing on the radio did not seem appropriate for people living at the home.

People on one-to-one care had care plans in place. However, the quality of care varied in relation to staff knowledge of the people they cared for. One staff member was able to tell us about the person they cared for, including their likes and dislikes. They knew the person well and knew how to support them to stay

calm. This helped to reduce the person becoming distressed and agitated. The staff member knew they enjoyed football and their favourite team. They understood their communication needs and their difficulty making verbal requests. They said care staff had to be very patient with them and when supporting them with personal care explain exactly what they were doing. Observation charts had been regularly completed. However, the person's 'this is my life' document aimed at collecting social and personal history had been left blank.

We found that agency staff did not always know people well. For example, a permanent staff member was able to tell all about the person, the reasons why they required one to one support, including any risks. Whereas an agency staff member told us that they did not know the person very well and had made no attempts to review their care plan. The consultant informed us that agency staff attended handover meetings where detailed handover notes are reviewed.

We concluded that the above was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The service had a complaints policy. Posters on how people can make a complaint were displayed in the reception and communal areas of the building. We saw that the service had recently introduced a comments and complaints box in main reception area. People using the service told us, "I don't know I guess I would talk to someone if I could find them [staff]." Another person said, "I would talk to the manager I think we have a new one." Relatives told us, "In the past year no, everything has been going well now," "No complaints" and "I think the last time I made a complaint was over a year ago. Since then it's been going well."

Inadequate

Is the service well-led?

Our findings

The service has undergone a number of changes over the past six months. This included the appointment of two new managers and deputy managers. The service has not had a registered manager since February 2016, despite this being a condition of their registration. The operations manager told us that they had recently appointed a new manager who would be starting in January 2017, initially part-time, then moving to full time later on. The service had undergone a number of changes which had led to inconsistencies to the delivery of care.

We found systems to monitor the quality of the service had failed to improve the quality and safety of the services provided to people living at the home. Records relating to incidents and risks were not up to date and people did not receive care that was always safe and respected their human rights. This included ensuring that people received care that respected their dignity and maintained their independence. Although staffing levels had increased, the deployment of staff meant that people's individual needs were not always met. The environment was not dementia friendly and people did not always feel safe.

The service had appointed a support consultant with experience of supporting homes experiencing quality and compliance issues. The consultant told us that she was in the process of reviewing people's care plans and risk assessments. Although the service had reviewed 14 care plans and risk assessments since our last inspection in July 2016, 50 had not been reviewed. We saw some evidence of audits in care records reviewed on the day of our inspection.

Although some of the issues raised at our last inspection in July 2016 had been addressed, such as PRN protocols and best interest decisions for covert medicines, care plans in place for people receiving one-to-one care and recruitment of permanent staff to improve staffing levels. However, we saw from the service's action plan that some of the actions listed had not been fully addressed, such as audits of people's care records, people being neglected and not treated with respect at all times and failure to ensure that accidents and incidents were appropriately reported and acted on.

The lack of leadership and stability at the home over a period of time has meant that the quality of care had not been maintained. The provider had failed to ensure consistency and continuity of care to people living at the home and people received care in a safe and caring environment.

We concluded that the above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We received mixed feedback from people who used the service and their relatives in relation to how they felt the service was run. Comments from people ranged from, "Not really, not enough staff," "I think so," and "I think everything is okay." People did not always feel their concerns were taken on board and acted on. One person told us, "I have told them about the time it takes to get an answer but no one comes back to me." Another person told us, "I hope they do, but I have no concerns to tell them."

Relatives told us that they were kept informed of what was happening with their relative. One relative told us, "Yes, they will always phone me and let know what is happening." Another relative said, "If something happened I get a call." We saw that the family notice board contained information for relatives, this displayed information about planned relative meetings for 2016. Relatives confirmed that they had attended meetings to discuss the running of the home, "I have been offered to go to one but I have never attended," "Yes, there was a meeting not too long ago," and "Yes, a couple of times a year."

Monthly catering audits took place, which included an action with areas for improvement. We reviewed mealtime allocation sheet, which was completed by staff during mealtimes.

We saw from health and safety committee meeting minutes for November 2016 chaired by the manager the agenda items included the review of accident and incidents, which showed that incident forms still required completion by staff.

We spoke with the local authority who told us that they had concerns about the quality of the service and was working with the provider to improve the quality of care.

In November 2016 the fire authority visited and the home was found to be satisfactory.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not always meet their individual needs and preferences. The provider did not always ensure that care and treatment of service users met their needs and preferences. Regulation 9 (1)(a)(b)(c).

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 The provider failed to ensure that service users were treated with dignity and respect and support their independence. Regulation 10 (1)(a)(b)(c)

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 The provider failed to ensure that systems or processes were established and operated effectively to assess, monitor and improve the quality and safety of the services, assess, monitor and mitigate the risks relating to the health, safety and welfare of service and maintain securely an accurate, complete and contemporaneous record in respect of each service user in the provision of care and treatment. Regulation 17 (1)(2)(a)(b)(c).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The provider failed to ensure that care and treatment was provided in a safe way to service users. This includes assessing the risks to the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks and the proper and safe management of medicines.

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 The provider failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed. Regulation 18 (1)(2)(a)