Queensland Care Limited

Homecroft Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Homecroft Residential provides personal care for up to 26 older people. The home is situated in a quiet residential area within the town of Ilkley. The accommodation is provided in mostly single rooms with a small number of double rooms. Some rooms have ensuite facilities. The home has a range of communal areas including lounges, dining room and gardens.

This was an unannounced inspection which took place on 20 April 2016. On the date of the inspection there were 18 people living in the home.

A registered manager was not in place with the previous registered manager leaving in April 2015. A manager had been recruited in October 2015 however they left in April 2016 before registering with the commission.

During our previous inspection in October 2015 we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to Good Governance, Safe Care and Treatment and Person Centred Care. As part of this inspection we checked whether improvements had been made in these areas as well providing an updated rating for the service under the Care Act 2014. At this inspection, we identified the provider had not made substantial improvements and was still in breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that a lack of management support still had a significant impact on the quality of the service. Like at the previous inspection, concerns remained about how risks were managed, the quality of care plans and the lack of robust audit procedures. There was a lack of established governance and audit systems at provider level to ensure the performance of the home was robustly monitored and improved.

Staff told us morale was affected by the lack of manager. We found that there was not a good working relationship between staff and senior management at the service.
Medicines were not managed in a safe way. A number of medicine errors had occurred and due to medicines being managed in a disorderly way, there was a risk that further errors would occur.

People said they felt safe from abuse in the home. Safeguarding procedures were in place and we saw these had been followed to help keep people safe. Staff understood the risks to people's health and safety.

Safe recruitment procedures were in place. Overall, we identified there were sufficient staff to ensure safe care. However staff were very busy which meant care was very task focused.

People spoke positively about the environment. We saw it was pleasantly decorated and safety checks on the premises were undertaken.
The service was not acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as staff and management were unaware of who had DoLS authorisations in place and the conditions attached. Consent was not consistently sought in line with the MCA.

People spoke positively about the food provided by the home. There was sufficient choice and action was taken to cater for any special requirements.

Staff had access to a range of training although some staff were overdue training updates in some subjects.

People's healthcare needs were assessed and appropriate plans of care put in place. People had access to a range of health professionals.

Staff treated people with dignity and respect. People spoke positively about staff and this was confirmed in the interactions we observed.

Care records were not sufficiently robust to demonstrate that people received responsive care. Records needed updating to ensure they accurately reflected people's needs. We saw a plan was in place to address this with more person centred care plans being put in place.

A programme of activities was in place. However some people told us there was not enough to do. Appropriate records were not kept of the activities people were involved in.

Overall complaints were appropriately managed, however we identified one complaint which had been missed by the provider and therefore not responded to.

Systems to assess, monitor and improve the service were not sufficiently robust. These systems kept changing which meant there was no consistent mechanism in place to drive improvement. Areas for improvement identified at the last inspection had not been acted on.

We found three breaches of regulation; you can see the action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

The service 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 improvements within this timeframe."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not consistently given in a safe way. We found a number of errors had occurred which put people at risk.

People and relatives told us they thought the home was safe. Risks to people's health and safety were assessed and understood by staff.

Safe recruitment procedures were in place. There were enough staff to keep people safe although staff were very busy which led to task focused care.

Is the service effective?

Requires Improvement

The service was not consistently effective

The service was not acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People told us the food was good in the home and we saw sufficient choice was provided.

Staff had access to training and supervision, however some of this was overdue.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about staff and told us care was delivered with dignity and respect. We observed some kind and caring interactions from staff.

Staff knew people well and information on their life histories had been obtained to aid staff better understanding people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and relatives told us the home provided good care. Care records were poorly organised with some information missing or not recorded in a clear way. This meant there was a risk that inappropriate care and support would be provided.

A programme of activities was in place although some people told us there was not much to do.

Is the service well-led?

Inadequate

The service was not well led.

A registered manager was not in place and the home lacked leadership and direction. There was a high turnover of senior management which meant systems and processes could not be effectively established.

No significant improvement had been made to the service following the previous inspection.

Homecroft Residential 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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also followed up on breaches of regulation identified at the October 2015 inspection.

The inspection took place on 20 April 2015 and was unannounced. The inspection team consisted of three adult social care inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with four people who used the service, four relatives, two care workers, an agency care worker, the cook, the area manager and the administrator. We also spoke with a health professional who regularly visited the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at elements of six people's care records, medication records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority.

Requires Improvement

Is the service safe?

Our findings

Medicines were not consistently managed in a safe way. In March 2016, we received two statutory notifications which stated two people had not received their required pain relief in January and February 2016. During the inspection we confirmed this was the case. One person was required to have a patch applied once every seven days. During February and March 2016 there were two 16 day periods when they had not received their pain relief. Another person was also required to have a patch applied every 7 days. We saw there were two instances in January and February 2016 when they had not receive their patch for 12 and 17 days respectably. Since this time, the patches had been given as prescribed and the provider had suspended the staff involved from medicine administration. However we were concerned that a chaotic approach to medicine management remained which could lead to further errors. For example there was a large number of handwritten Medicine Administration Records (MAR) which were not all double signed to check for errors and some people's MAR's were regularly changed mid-cycle. We identified some errors in the transcription of prescriptions onto hand written MAR charts. The area manager agreed these working practices were a risk, and demonstrated they were putting in place measures to improve the safety of the medicine system.

Due to staff suspension, there was a high instance of medicines being administered by agency staff. We saw this had led to some errors. For example a near miss had occurred in April 2016, where an agency staff member had gone to give the wrong medicines to one person due to being unfamiliar with people, fortunately this had been identified before the person had consumed the medicines.

We saw some good medicine management practice. For example arrangements were in place to ensure that medicines required at particular times were given at those times such as before breakfast. In most instances we saw evidence medicines were given as prescribed and most stock counts on medicines corresponded with what records indicated should be present. However we identified a number of instances where medicines were not given as prescribed and other instances where we could not establish whether they were given. Most of this related to Sunday 17 April 2016 when an agency staff member was working and a number of medicines were not given.

Some medicines were administered from monitored dosage systems. However we found some tablets had been taken from the wrong day, which caused confusion for staff and demonstrated unsafe management of medicines. For example when the agency staff came to administer medicines on the morning of the inspection to one person, they found the morning medication was missing from the blister pack, staff were unsure as to whether night staff had already administered the medicine earlier that morning. The deputy manager established through contacting night staff that this was not the case, but they were unable to explain why the medicine was missing.

We identified one person who had been discharged from hospital, one of their medicines had not been transcribed onto a MAR so there was no evidence that it had been given. We saw instances where documentation of topical medicine administration was poor, meaning we could not confirm whether these people received their medicines.

There was a lack of guidance for staff on when to administer, 'as required' medication such as for pain relief and behaviours that challenge. This was of particular concern as agency staff were administering medication on a regular basis.

Where people were given variable dose medicine, the number of tablets given was not consistently recorded. This made it impossible to reconcile stock balances for these medicines to determine whether tablets were accounted for or had been given as prescribed as indicated by records.

One person was receiving their medicines covertly. We saw evidence that health professionals such as the GP had been involved in the decision to allow staff to administer covertly. However there was no advice from the pharmacist to ensure the route of administration was suitable.

This was a breach of regulation 12 (1) (2g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medicines were stored securely. We saw they were given in a compassionate way by staff who checked whether people were okay and asked their consent before administering medicines. The date of opening was written on the side of bottles to ensure that staff were clear when it would expire.

We looked around the premises and found it was generally managed in a safe way. People spoke positively about the building, telling us their rooms and living environment was comfortable. We saw the service had received an Enforcement Notice from West Yorkshire Fire Service in March 2016. We saw evidence that some action had been taken to comply with this notice and the area manager told us that the remaining items of concern would be addressed within the agreed timescales. We saw electrical items had been safety tested and machinery such as hoists and stair lifts had been serviced. The home had a system to monitor service dates for all equipment used. For example we saw evidence water was tested for temperature and legionella and fire equipment was serviced regularly. The home had a current gas safety certificate in place. A system was in place to report and rectify defects to the premises. We looked at the jobs list and saw tasks were actioned within a reasonable timescale. The home was decorated appropriately. Bathrooms had recently been modernised and people's bedrooms were personalised in line with the person's taste.

Some people and relatives told us they were disappointed that the chairs and music system in the area behind the main lounge had been removed meaning there was no longer a quiet area to relax away from the main lounge. We saw this had been done by the provider in response to a visit by the fire service. The area manager told us they were looking at ways to provide additional space for people without compromising fire safety.

The premises was clean and well presented. We saw that daily temperature checks were documented for the fridges in the kitchen. The home had achieved a five star hygiene rating from the local authority.

We assessed staffing levels within the home. Overall we concluded there were sufficient staff to ensure safe care. People and staff told us there were usually enough staff on duty. The area manager told us normal staffing levels were three care workers during the day and two at night with a fourth care worker during the day when an unfamiliar agency staff member was on shift. However there was only two care workers and one agency on duty on the day of the inspection due to last minute sickness. This was reflected in the some of the comments we received, "They must be short staffed again today, there will be staff around somewhere." The service had experienced staff shortages and as such as was using a high proportion of agency staff for example between 26% and 44% of care workers were from the agency in the three weeks prior to the inspection. The area manager told us they had recruited further permanent staff who were

awaiting start dates.

At the last inspection we noted that although there were enough staff to ensure safe care, there was sometimes a lack of staff to provide stimulation to people. At the time we spoke with the area manager who said that they thought they needed four permanent care workers on shift to allow more trips out and activities to take place and they were taking steps to address this. At this inspection we identified staffing levels still meant care was very task focused particularly in the busy morning period.

One person required one to one care and we saw arrangements were in place to ensure this was provided.

Safe recruitment procedures were in place. Applicants completed an application form and attended at interview. Successful applicants had their identification checked, provided references, and undertook a Disclosure and Barring Service (DBS) check. This is a background check conducted on staff to help provide assurance they are safe to work with vulnerable adults.

Risk assessments were in place in people's care files for example falls and nutritional risk assessments. Where risks were identified, plans of care were put in place to assist staff in controlling these risks. Although we concluded that staff knew people well and how to keep people safe, care plan documentation was not clear or person centred enough to demonstrate a robust risk management system. Personal evacuation plans were in place which detailed how to evacuate people safely in an emergency.

People and relatives told us people were safe in the home. For example one relative told us, "I wouldn't leave [person's name] here unless they were safe." They also said, "Staff are always looking out for her. I can't fault them." The service followed the West Yorkshire Safeguarding Procedures and we saw appropriate referrals had been made to the local authority where concerns had been identified. We saw the services whistleblowing policy displayed in the entrance hallway to bring it to the attention of staff. Staff we spoke with demonstrated they knew how to identify and act on concerns.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the last inspection we found the home was not consistently acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as appropriate applications had not been made.

At this inspection we saw that the home had initiated 'Restrictive Practice Assessments' for a number of people, with consultation with the GP, home manager, social worker or family. This demonstrated the service was assessing the restrictions placed on people and trying to ensure care and support was delivered in the least restrictive way possible. We found DoLS applications had been made for a number of people who lived at the service demonstrating the correct process had been followed. However there was confusion about who had an authorised DoLS in place with staff and the area manager being unsure. We received two notifications about DoLS authorisations in place since the last inspection, but staff and management were unable to clearly identify these two people as having DoLS in place. We identified a further person who had a DoLS authorisation in place which had not been notified to us. This person had a condition attached to their DoLS around assisting them to remain occupied and to contribute around the home. However the staff were unaware of this conditions and their social and religious and cultural activity section of their care plan was blank. There was no plan in place to ensure this condition was met. We found this lack of oversight of DoLS meant there was a risk people's rights would not be protected.

This was a breach of Regulation 17 (2a) of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

Prior to the inspection we received concerns that one person had been moved bedrooms without proper consent and a best interest process had not been followed. During the inspection, we confirmed this was the case, but identified that they had been moved back to their old room within 24 hours after determining that the room was not suitable for the person. However we were concerned that this person who lacked capacity to consent to their care and treatment had been moved rooms at short notice in the first place without a thorough best interest process followed. Records in the daily record showed that the person, 'was very confused about being in their new room' and that they '[person] had to walk up the stairs even though their foot was very swollen'. The lack of best interest process for this decision demonstrated that appropriate consent had not been sought. In some care plans, there was a lack of evidence that people had consented to their care and treatment in their care plans.

This was a breach of Regulation 11 (3) of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations.

People were supported appropriately to maintain good nutrition. People were seen to enjoy a choice of fresh home-made meals and menus were rotated to offer a variety of foods. One person commented about their food, "It's lovely." A second person told us, "The food is good, I always have a good breakfast." A relative told us, "The food's great." We heard staff giving people a choice of what they wanted to eat at mealtimes, approaching each person individually and writing down their choice.

We observed the lunchtime meal and saw that food was delivered from the kitchen in containers placed into a catering lift. The containers were placed on a serving trolley in the dining room and meals were plated on an individual basis according to people's choices. However, we saw that some people were waiting 40 minutes before they were served their meal and a further 15 minutes before dessert was served. When we asked one person about the speed of service they said, "We just put our hands together and pray." This indicated to us that this was not an isolated incident. However, we saw that a staff member apologised to people about the delay and initiated a 'sing song' and a reminiscence discussion whilst waiting for food. We saw this staff member engaging with people during and after the meal, sitting and chatting, which people responded to positively.

Some people chose to eat in their rooms and we saw staff taking the meal of their choice to them. People were encouraged to eat at their own pace and we saw staff gently reminding one person about the food in front of them, and turning the plate of another person so they had easy access to the food. We observed that the service was flexible in meal times. For instance, one person had had a lie in until mid-morning and was offered breakfast when they came downstairs. Another person had been asleep when lunch was served and we saw staff made sure the person had a full meal of their choice when they awoke.

The area manager told us that the service employed a cook for four days and were recruiting for a second cook for three days. The cook on duty was able to tell us how they fortified meals using full fat milk, butter and cream. The food they prepared looked appetising and nutritious. They were aware of a diet information sheet that was on the wall of the kitchen. We saw from this sheet that one person could not eat root vegetables. We saw this was adhered to at lunchtime as this person was not given carrots. A choice of fruit juice was offered at lunchtime and a choice of hot drinks and snacks were offered at other times during the day and evening.

People told us they had access to a range of health professionals. For example one person told us, "They call the doctor if I need them." We saw evidence of involvement from the multi-disciplinary team including G.Ps, district nurses, dieticians, opticians, occupational therapists and physiotherapists. Health related care plans were seen to be reviewed, updated and signed by staff. Staff we spoke with had a good understanding of the healthcare needs of the people they were caring for. We spoke with a visiting health professional who told us that overall they thought the service contacted them appropriately and acted on their advice. They told us they had no concerns about the standard of care provided by the home.

People and relatives we spoke with said staff had the right skills and knowledge to care for them. A range of training was provided to staff on induction and at periodic intervals. We looked at the training matrix and saw the majority of staff had completed their mandatory courses in subjects such as health and safety, safeguarding and manual handing. We identified that some staff were overdue updates, however the area manager showed us a plan was in place to address these shortfalls. Staff told us the training courses were valuable and gave them the skills they required to complete their duties.

We looked to see how people were supported with their work life and professional development. Management changes within the home had an effect on levels of support offered to staff. The area manager told us that staff should receive a minimum of six supervision meetings per year. We looked at the matrix for planned support and saw only three staff had received supervision in 2016. Appraisals had been booked for March 2016 but none of these had yet happened. The area manager confirmed they were aware the home was behind with supervision and apprasial but plans were in place to address. We looked at staff members last supervision notes. Supervisions were created alongside the five key questions used by the commission. This ensured when supervisions took place, they were meaningful and covered a comprehensive list of areas.

Team meetings had been held regularly. We looked at the notes from the last team meeting and saw they included information to assist with the provision of effective care. For example, we saw notes from a discussion around changes in people's risk assessments, care plans appropriateness, changes with menus and a reminder to all staff to sit with people if they have the chance.

Good

Is the service caring?

Our findings

People and relatives consistently described staff as kind, caring and friendly. They said they knew staff well and they treated people with a high level of dignity and respect. For example one person told us, "Staff are very good, lucky to get in here, they are caring and the home is nice." Another person told us, "Oh the staff are all very nice, I've lived here for a while I think, but it's very nice." A third person said, "I'm happy enough here." One person's relative told us, "[Person's name] likes it here. [Person's name] sees some of the staff and beams, holding her arms out for a hug, which they give her."

We observed care and support in the communal areas of the home. Staff showed a caring manner towards people and we saw evidence of some good interactions between staff and people who used the service. For instance, we saw staff singing with a group of people whilst waiting for lunch and chatting with people about their life experiences. We saw a staff member discretely assisting a person to cut up their food at lunchtime and gently encouraging them to pick up their fork so they could eat independently. When staff had time we saw they were committed to talking to people and asking them about their day. We saw comfort provided to people to reduce and alleviate any anxieties they may be experiencing.

Although a large number of agency workers were used by the service, the provider had taken action to try and ensure the same agency staff were used. We spoke with an agency worker on the day of the inspection who had an adequate understanding of the people who lived there, having been at the home a number of times. A number of other staff who worked at the service were long standing and it was evident they had developed strong relationships with people who used the service and their relatives. Staff demonstrated an in-depth knowledge of the people they were caring for and their needs. People and relatives we spoke with said staff understood them and they knew them by name. Information on people's biographies was present within their care plans which demonstrated staff had taken to time to listen to people and learn about their lives.

We saw staff listened to people and valued their opinions in day to day life within the home. For example staff asked people where they wanted to sit and what they wanted to do. Staff asked for consent before tasks such as assistance with food and medication. Care plans focused on ensuring people's preferences were met.

The service supported people to maintain their independence. For example we saw staff encouraging people to mobilise around the home on their own. Some people were able to be independent with some of their own medicines and staff were aware of this and supported them to be able to do this.

Visitors were welcome to the home at any time and we saw evidence that staff assisted people to spend time privately with visitors such as in the garden.

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us they were satisfied with the quality of care the home provided. They said staff met their needs and provided care in a timely and appropriate way. Staff we spoke with demonstrated a good understanding of how to care for the people we asked them about.

At the last inspection in October 2015 we identified that some people had only basic short term care plans in place which did not detail their current needs. At this inspection, we identified that these had been replaced with long term care plans. These included 'what I prefer', 'what I can do', 'what I need assistance with' and 'what's important to me.' Care records demonstrated that in some instances people's needs had been assessed. However the organisation of care records was very poor which meant some information was missing or duplicated. Care plan folders were stored in various parts of the upstairs office and were in a poor state of repair. A large number of care plan folders had their covers missing, which contained the person's name and photograph. This made the care plans hard to identify. We found loose paperwork from people's care files in the bottom of the filing cabinet drawers. We found the lay out of the care records to be confusing, with some documentation duplicated on adjoining pages, such as concerning specific care plans. It was unclear from care files what were assessments, what were reviews of assessments and what were care plans or care reviews. We saw some care plans pages not completed, for instance religious spiritual or activities and social information. There was no evidence of the person or relatives having input into the care plan, or review meetings held between the person and their key worker, although the relatives we spoke with told us they felt involved. We concluded that the care plans we saw were not robust or contained sufficient person centred information to demonstrate responsive care.

This was a breach of Regulation 17 (1) (2c) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

We spoke to the area manager who demonstrated to us they had recognised care plans were not fit for purpose and told us they would be implementing a new format of care plan which would be easier to understand and use. We saw evidence of this and were confident documentation would improve if these were implemented. We saw that there was a space on these new care plans for the person to sign their agreement with the care plan.

Activities were arranged by the service but we concluded more social interaction could have been provided to some people. The home employed an activity co-ordinator who worked once or twice a week within the home and also organised events and trips. We saw a programme of activities between Tuesdays and Fridays displayed on the noticeboard in the hallway, although the dates were for the previous week. This included chair based exercise, music and activity sessions, craft sessions and reminiscence. We saw that the service had an Italian Themed Day the previous week. However, the activity sheet was not easy to read by people who used the service since it was typed in small print, with small pictures, and some information was crossed out or amended. We also found there was a lack of record of the activities people had actually been involved in, which made it difficult to assess whether there was appropriate provision. During the inspection we saw people were left for long periods without meaningful stimulation. Some people told us

there was not enough to do in the home. For example they said, "I get bored, not much to do." In the afternoon we saw an outside company come in the afternoon to do a music session, dancing and quiz and some people chose to sit outside in the sunshine.

People and their relatives told us staff listened to them and addressed any minor concerns raised. They said they were generally satisfied with the service albeit some had concerns about the lack of management at the home. The home had a complaint procedure in place which was brought to the attention of people who used the service. The procedure listed the definition of a complaint and action that should be taken to respond to a complaint. These actions included time frames for responses. We found three complaints had been received since our last inspection. Two of the complaints had been responded to in line with the provider's policy. However there was one complaint received in the file that had no action taken against it, despite being received in March 2016. We found management were unaware of this complaint and we attributed this to the chaotic nature of records and lack of registered manager rather than an unwillingness to respond to complaints.

Inadequate

Is the service well-led?

Our findings

The home had submitted most statutory notifications to us such as DoLS Authorisations and allegations of abuse. However we found one DoLS authorisation which was in place which we had not been made aware of by the provider.

At the previous inspection in October 2015 the home was without a registered manager or anyone in day to day charge of the service. We found this had a significant effect on the quality of the service. Following the last inspection a manager had been recruited however they had resigned in early April 2016 before registering with the Commission. There had also been several other changes at provider level with the four managers we liaised with at or following the last inspection having now left. At this inspection, the home was once again without a manager in day to day control of the service. Another area manager had taken responsibility for the home since the middle of April 2016 and told us they were now spending one or two days a week at the service until a new manager started in May 2016. We were concerned that these factors were a major barrier to providing a high quality service and that no significant improvement had been made to the service following the previous inspection. The lack of continuity of senior management was a long standing problem, for example at the previous inspection we noted there had been a significant number of management changes within the provider during the past few years.

During this inspection we were impressed by the current area manager's commitment and vision to improve the service. For example they were open and honest with where the service currently was and sent us a number of assurances following the inspection of their commitment to drive improvement. They told us a new home manager was due to start on 16 May 2016 and a clinical lead would be providing increased clinical governance for example around medicines management. However given our previous findings and the high turnover of management we did not feel appropriately assured that these changes would be sustainable.

At the last inspection staff told us morale was not good and that the home lacked direction. At this inspection we found this was still the case with one staff member telling us, "Seen a decline in this place, just need a manager." We found there was not a good working relationship between senior management and staff that worked at Homecroft. One consequence of this was staff not following instructions disseminated by management. Staff also told us they felt unsupported by the management structure.

At the last inspection we found appropriate systems were not in place to assess, monitor and improve the quality of the service. During the last inspection, we were assured by the area manager at the time that they were developing a service wide audit system which would help improve the service. Following the inspection they had left and these plans had not been completed. Another area manager had taken responsibility for the service and had completed one provider audit in March 2016, however this had not been sufficiently robust with many areas of audit deferred until the 6 April 2016. This manager had then left the organisation before completing this second audit and the small number of actions put in place from the March audit had not been completed for example ensuring daily walk arounds were done and ensuring one resident per day was audited. At this inspection, the new area manager we spoke with showed us they were

now developing a new system to assess and improve the service, however this was not yet in place. We were concerned that the lack of continuity of management meant robust governance and audit systems could not be established and effectively operated.

We found a number of areas where the quality of the service was not being monitored properly. For example staff or management at the home were not able to clearly describe who had a DoLS authorisation in place and were not aware of the conditions attached to one DoLS authorisation. Without knowing this information, there was a risk that people's rights would not be protected. The area manager told us they would develop a system to ensure greater oversight of the DoLS process.

We found a number of issues with medicines management which demonstrated an appropriate system to assess, monitor and improve the medicines management system was not in place. We identified that medicine audits were not being undertaken at a regular frequency and were not sufficiently robust. For example two medicine audits had occurred in February 2016 but neither had identified that people had not been receiving their pain relief at the required intervals. This was only identified at the end of March 2016 when the manager at the time had been administering medicines which was between three and 8 weeks after the errors. This demonstrated the system was not sufficiently robust. However once the errors had been identified, we found the provider had taken them seriously and was enacting disciplinary procedures.

One person's care plan stated they needed their fluid intake monitoring to ensure they stayed hydrated. However, this person did not have a fluid monitoring chart in use. We spoke to staff who said the person did not have a fluid monitoring chart since staff knew they were to encourage them to drink plenty, however this demonstrated a lack of appropriate monitoring of their health.

We identified other examples where the service had not fully acted on our feedback following the last inspection. We identified that people's views were still not formally recorded as part of care plan review, although we saw a plan was now in place to address this. At the last inspection, we found the provider's policies and procedures were out of date and referenced old legislation. At this inspection we found this was still the case with the area manager told us the policy review was not yet complete. We saw a small number of policies had now been updated such as medication but others such as safeguarding were still to be completed.

We found a number of discrepancies still remained with care plan documentation. Some sections of care records were often blank, poorly completed and contained insufficient information. A small number of care plan audits had been conducted in March 2015, these had identified that some documents such as people's future wishes were not complete. However these actions had not been completed at the time of the inspection showing the audits were not effective. General records were poorly maintained with a chaotic approach to document management. Incident records were not appropriately stored and we found a complaint had not been responded to because it had not been promptly passed to the provider for investigation.

At the last inspection we found audits were not carried out at regular intervals. We found this was still the case although some improvements had been made. Since the last inspection, the manager had conducted a range of audits which included care plan audits, weight and mattress audits. However some of these had not been completed in March 2015 for example weight audits, and mattress audits had not been completed. Documentation showed infection control audits were due to be completed every three months but hadn't been completed since September 2015. Again we had concerns that the service had failed to ensure continuity in the quality and presence of audits as part of a robust system of quality assurance.

At the last inspection we found incident analysis did not contain all the incidents which occurred in a particular month making it difficult for the service to monitor trends within the service. We found this still to be the case with incidents which had occurred in January and February 2015 not included in the analysis. There was also a lack of incident analysis completed for March 2016. Where incidents had occurred there was a lack of evidence of robust actions put in place to prevent a re-occurrence. We saw a recent near miss had occurred where a wardrobe had been knocked over by a person. Although action had been taken to attach the wardrobe to the wall, this had not been applied to other rooms within the home, demonstrating a lack of thorough learning from incidents. Incident records stated that 25% would be reviewed by management as part of a system of governance, we saw this had not been done for any incidents in January to March 2016.

We also found the lack of a stable staff team contributed to problems with the overall quality of the service. A high number of agency staff were being used and the area manager told us they thought this was responsible for some of the discrepancies we found with medicines management.

People and relatives generally spoke positively about the overall quality of the service. They said they were happy and content in the home. However two relatives told us they had concerns over the lack of management within the home. One relative said, "Girls are great, but management is non-existent ."

People told us that periodic resident meetings took place and that staff listened to them. We reviewed minutes from these meetings and saw these were an opportunity for issues such as activities and food to be discussed. We saw actions from previous meetings had been signed off.

People's feedback had also been sought through an annual satisfaction survey completed in December 2015. The results from this were mostly positive. However we found where actions were identified they had not been effectively carried out. For example one of the actions was that, 'a diary will be used to record all activities people have been involved in' and formal care reviews would take place. However these things had yet to be actioned by the provider.

This was a breach of Regulation 17 (1) (2a) (2b) (2c) (2e) (2f) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

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 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	Regulation 11 HSCA RA Regulations 2014 Need for consent (3) Where a person lacked capacity to consent to their care, the service had not acted within the Mental Capacity Act 2005

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (2g) Medicines were not managed in a safe way

The enforcement action we took:

We issued the provider with a warning notice requesting compliance with this regulation by 3 June 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (2a), (2b), (2c), (2e), (2f) Systems were not in place to assess, monitor and improve the quality of the service. Systems and processes were not in place to assess, monitor and mitigate risks to people's health and safety. An accurate and complete record of each service user was not maintained. Other records concerning the management of the regulated activity were not maintained. The service had not acted on feedback from relevant persons for the purposes of continually improving the service.

The enforcement action we took:

We issued the provider with a warning notice requesting compliance with this regulation by 1 July 2016.