S & S Healthcare Limited

Darnall Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place 1 March 2017 and was unannounced. The home was last inspected in September 2015 at which time it was rated as requires improvement, with ratings of good in safe, caring and well-led. We found the required improvements had not been made since our last inspection.

Darnall Grange offers residential and nursing care for up to 60 older people, some of whom have a diagnosis of dementia. The home offers accommodation over two floors.

There was no registered manager at the time of the inspection; however there was a manager in post who was in the process of registering with the Care Quality Commission. 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.

Staff had undertaken safeguarding training, however not all staff had received up to date training. There had been incidents which had not been recognised as safeguarding and had not been reported to the relevant bodies as a result.

Risk assessments did not identify individual risk and did not explain to staff the measures which needed to be in place to keep people safe.

There was a recruitment process in place which was being followed; this included carrying out all necessary pre-employment checks including disclosure and barring service (DBS) checks and references from previous employers. However we found there was no process to carry out checks on people's DBS status to ensure people remained suitable to work with vulnerable adults.

There were sufficient staff on duty, however due to the design of the building there were periods where people were left unsupervised in communal areas.

Medicines were not always managed or recorded safely.

Staff had undertaken some training, however there were gaps in the training and support of staff which meant they may not have the skills and knowledge required to carry out their roles.

The home was not always working within the Mental Capacity Act 2005, and had not carried our best interest decisions or applied for Deprivation of Liberty Safeguards for all the people that required them.

There were some issues with weight loss and there was little evidence the home was taking adequate action where people had lost weight.

Staff were kind, caring, considerate and sympathetic. However whilst staff knocked on doors and waited for response which protected people's dignity, we also found people without shoes and glasses and people who were wearing food stained clothing.

Care plans were not person-centred and did not always reflect the current needs of people who lived at the home. The care plans were reviewed each month, however the reviews did not add current information into people's care plans to ensure they were current.

There were a variety of activities taking place in the home. People and their relatives enjoyed the activities which were on offer.

There was clear leadership and management in the home.

Processes to monitor the safety and quality of the home were not effective and had not identified some of the issues we found during the inspection; this meant the registered provider did not have oversight of the performance of the home.

The registered provider had not ensured they notified us of all events which affected the running of the home or the people who lived there.

You can see what action we told the provider to take at the back of the full version of the 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.

Staff had been trained in safeguarding vulnerable adults. However we found there had been incidents which had not been recognised as safeguarding concerns which had not been appropriately reported.

Risk assessments did not identify individual risks or show staff the measures which needed to be in place to keep people safe.

Medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had undertaken training; however this was not always refreshed as regularly as it should have been. Staff were receiving supervision meetings but there were no appraisals taking place.

The service was not always working within the principles of the Mental Capacity Act 2005, and consent to care was not being sought or gained in most cases.

People had access to a food and drinks; however we found there were issues with some people losing weight and appropriate action had not been taken.

Is the service caring?

Requires Improvement

The service was caring.

Staff were kind caring and compassionate when supporting people.

Whilst staff maintained people's dignity in some respects for example knocking on doors before entering, we found people were left without footwear and glasses.

We saw little evidence of people being encouraged to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not detailed or person-centred and contained conflicting information. Reviews did not update care plans where there had been a change to a person's needs.

There were lots of activities taking place in the home, and people were enjoying them.

There had been only one complaint recorded, this had been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The new manager was reported by all to have made a positive change to the home since being in post.

The registered provider had not notified the Care Quality Commission of incidents which they needed to tell us about.

Records were not of a good standard; processes for the monitoring of the quality and safety of the service were not effective or robust.

Darnall Grange

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place 1 March 2017 and was unannounced. The inspection was carried out by two adult social care inspectors 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 the expert had experience of older people's services which included the care of people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sought feedback from the commissioning authority who gave us positive feedback and reviewed all the information we held on the home prior to our visit.

During the inspection we spoke with one of the Directors, the manager, six care staff, the cook, the activities coordinator, the administrator and two visiting health professionals. We spoke with nine people who lived at the home and nine relatives who visited the home during the inspection.

We accessed records including the care files for six people, recruitment files for four staff, accident and incident records, Deprivation of Liberty Safeguard records (DoLS), safeguarding records, auditing which had taken place and all records relating to the health and safety of the building.

Inadequate

Is the service safe?

Our findings

People we spoke with told us, "I am so pleased to be in a safe place at last", "I am so grateful to be feeling safe" and "This is home from home for me. The staff keep an eye on us all the time."

Relatives told us, "We are so pleased that [relative] is now in a safe place. I can settle now", "I have every confidence that [relative] is in a safe home", "[Relative] is so much safer than when he was at home, it is reassuring", "Keeping people safe is paramount here", "They keep [relative] safer here than I could at home", "I can absolutely say this is a safe place" and "Make no mistake [relative] would not be here if I didn't think it was safe."

All the relatives we spoke with were confident that their loved ones were safe and well cared for, however some of them felt that people were not always supervised, as sometimes there were not enough staff.

Staff had in most cases undertaken training in safeguarding vulnerable adults and were aware of their role and responsibilities keeping people safe by reporting any concerns. One member of staff told us, "I feel really confident about protecting people and I know we have a whistle blowing procedure". We found there had been incidents which had taken place in the home which should have been recognised as safeguarding concerns, however this had not happened and whilst some incidents had been reported to the local authority safeguarding team, they had not been reported to the Care Quality Commission. This meant that some incidents were not being reported or investigated appropriately.

This was a breach of Regulation 13 safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the risk assessments which were in place for people. We found there were some assessments of risk, however these were 'tick box' forms and in some cases they were incorrectly completed which did not give a true reflection of the level of risk, for example we found a skin integrity risk assessment, in which the person had a pressure area, however this had not been recorded which gave a lower risk score than was accurate. This was raised with the manager who said they would take action to ensure the risk assessment was correct. The risk assessments did not identify specific risks and there was no explanation of the measures which were needed to be employed to ensure people were safe.

This was a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as risk was not adequately assessed and there were no clear measures in place to minimise risks.

We found there were records of accidents and incidents, and there were significantly more records for February 2017 than there had been for January. We asked the manager about this, who told us this was because staff reported incidents and accidents more consistently in February. We found there had been incidents reported which had not been followed up, for instance there was a record of a person being found to have a dislocated finger, there had been no investigation into how this had occurred, however there had

been appropriate action taken to ensure they received medical assistance in a timely manner.
We found there had been a number of falls during February, we discussed with the manager that the lack of people wearing their glasses could be a contributory factor, the manager assured us they would take immediate action to correct this.

We found there was sufficient staff on the day of the inspection, however due to the design of the home there were times when staff were not visible in communal areas as they were assisting people in their rooms. We asked the manager how they calculated the number of staff required, they told us there was no formal tool to calculate this, however we found there were dependency tools in individual files which gave the impression people required intensive staff support, where this was not the case in practice.

We reviewed the recruitment files for staff employed at the home. There was a number of staff who had worked at the home for many years. We found that whilst there had been appropriate checks carried out prior to people commencing work, there had not been any checks carried out since then. In the case of Disclosure and Barring service (DBS) checks, these had not been renewed since people started working at the home, and in two of the three files we reviewed the DBS check was dated 2004.

We reviewed how the home managed medicines. We found there was a treatment room on each floor of the home, the doors to the treatment rooms were locked and had a key pad to gain access; however we were concerned that the code was written on the door, which meant unauthorised people could gain access, we raised this with the manager who told us they would remove the codes from the doors to improve security. Medicines inside the rooms were kept in locked trolleys and cupboards, the keys for which were kept with the member of staff who was in charge of the administration of medicines for the shift.

We reviewed the medication administration records (MARs) for people on the ground floor of the home. We found there were 'codes' listed on the MARs for staff to use to show what action had been taken. One of the codes was 'F' which was listed as 'other – define'. There was space on the back of each MAR for the definition to be recorded. We found there were a large number of records showing 'F'; however there were no definitions recorded for any of them. In one instance we found a person had been prescribed a pain killing gel, this had not been applied for several weeks, there was no reason recorded why this was the case and no record this had been reported to anyone. Another person was prescribed oral pain killers and there had been multiple times when this had been recorded as 'F' again there was no reason recorded. We raised this with the manager who told us they would take action to ensure people received their pain relieving medicines where they were needed.

We found other MARs where there were signatures missing, which meant we were unable to determine whether the medicine had been administered to the person in line with the prescriber's instruction. We noted on one case a person was prescribed a medicine to help them sleep as and when required (PRN), the records showed there had been no doses given, however when we checked the number of tablets which were in stock against the records there had been one dose given, we were therefore unable to ascertain when this medicine had been administered. We found another instance where we found there had been 28 tablets delivered for a person, the MAR showed there had been 17 tablets administered, yet there were 17 tablets still in stock, which meant the person had not received their medicines in line with the prescriber's instructions.

We noted there were letters from people's doctors in some cases authorising the home to give medicines covertly (without the knowledge of the person receiving the medicines). The use of covert medicine administration should only be considered where a person lacks capacity and is unable to make their own decisions about the treatment they receive, and where a best interest decision has been made to show the

reasons for the decision and why it is necessary. The use of covert medication administration should be regularly reviewed and there should be a clear plan in place to show the reasons, methods and medicines which are to be given covertly. We found there were no best interest decisions in place for any of the people we reviewed. We discussed this with the manager who assured us they would take action to rectify this.

We reviewed the use of as and when medicines (PRN). These are medicines which are prescribed to people where they are only needed at some times, for example pain killing medicines. Where PRN medicines are in place there needs to be a protocol which explains the reason for the medicine, how staff would know the person needs the medicine, what effect the medicine should have and any circumstances where staff needed to consult the prescriber of the medicine to review its use, for instance if the person had not required the medicine for a period or the medicine was not having the desired effect. We found no protocols in place for any of the people whose records we reviewed who had been prescribed PRN medicines.

We checked procedures for the safe handling of controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found the controlled drugs were stored appropriately in a locked cupboard and there was a controlled drugs register in place to record the use of these drugs. We checked the records and stocks of controlled drugs for people on the ground floor of the home, and found they were correct in all cases with records matching the stock of medicines held for each person.

It is essential that medicines are stored at the correct temperatures to ensure they remain effective. We noted that the temperatures of the medicine storage areas were not always checked each day, however we did not see any records which indicated the room was not at the correct temperature. This was also the case for the medication fridges in both treatment rooms.

Medicines for people who required nursing care were administered by a qualified nurse; people who did not required nursing care had their medicines administered by a trained senior care worker. We found there had been competency checks carried out by qualified staff to ensure staff who were administering medicines were competent to do so. People told us, "I get my medication just when I need it" and "You don't get your tablets until you get up and it's up to me when I get up". A relative said, "[Relative] takes regular pain killers. They always get them on time when I am here, and I visit at different times".

There was a breach of Regulation 12 safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as medication administration records were not correctly completed, covert medication protocols were not in place and there were no protocols for the use of PRN medicines.

We asked for access to the safety certificates for the home, including gas and electrical installation; lift and equipment maintenance, legionella checks for the water supply and fire records. We were told these were not available in the home on the day of the inspection and would be sent to us following the inspection. These certificates were supplied to us after the inspection and showed the building was safe.

The home appeared clean and was free from odours. We noted there were domestic staff on duty throughout the day and there were cleaning schedules which showed all areas of the home were regularly cleaned. The home had recently replaced the majority of the carpets with easy clean, non-slip flooring to reduce the risk of malodours.

Requires Improvement

Is the service effective?

Our findings

People told us, "You can ask for anything and they will make it for you", "I have no idea what is for lunch today" and "I'm alright with what I get".

Relatives we spoke with said, My [relative] has a whole range of health care professionals coming in. Staff are great at communicating they keep me informed of everything", "We do not know what is for lunch but there is a menu in the dining room" and "They have told us that they are going to invest a lot on money in the home".

We reviewed the training records for the home. We found that whilst training was being undertaken not all staff had up to date training in key areas for example, five care staff did not have current moving and handling training, and 10 care staff had not undertaken training in the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). We also noted a large number of staff were not recorded as having taken part in a fire drill (only eight from the 31 care staff listed on the training matrix).

Staff told us they received regular supervision, and the files we reviewed confirmed this was the case. Staff reported feeling supported by the manager and the registered provider. There had been no appraisals taken place for a significant period and not since the manager had come into post.

This was a breach of regulation 18 staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff had not all received the training needed to ensure they were suitably qualified and competent to carry out their role.

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). We found in the care files we reviewed there had been applications made to the local authority to authorise the deprivation of people's liberty, and in these case there had been an assessment of the person's capacity to make their own decisions about their care and treatment.

We reviewed the DoLS files which were in place in the home, and found that the records were not in the correct files and there were a large number of DoLS applications for people who were no longer at the home. The manager told us in their opinion every person in the home lacked capacity and needed an application to be made for DoLS. The manager told us they were in the process of completing these.

We found in one case a DoLS had been authorised, and there were conditions attached to the authorisation which related to updating the person's care records and the use of covert medicine administration. There was no evidence the conditions specified by the authorising authority had been met.

We reviewed the process for seeking and gaining consent from people for the care and support they received. We found there were mental capacity assessments in place which showed people lacked the capacity to give their own consent, however there was no evidence that where other people for instance relatives had given consent on someone's behalf that they had the legal right to do so. People can appoint an attorney to act on their behalf, this is usually a family member or close friend, in some cases the court of protection will appoint an independent person to act on a person's behalf where they have no one they could ask, this is called a Power of Attorney (POA). A POA is a person who has been legally authorised to make specific decisions on behalf of another person by the Court of Protection; this can be in relation to health, finance or both. We also saw no evidence that best interest decisions had been made to ensure people's rights were protected. We discussed our concerns with the manager who assured us they would take action to correct this.

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

People we spoke with gave very differing opinions of the food they received in the home. Some people complimented the food with comments including, "I like all the food they give us", "The food is grand, it's just how I like it", "You can ask for anything and they will make it for you" and "The fish and chips are homemade, lovely". Whilst others reported it was sometimes cold. People commented, "The food is alright but its cold most of the time" and "Sometimes it's (the food) cold". We noted on the day of the inspection the menus on display corresponded with the meals on offer, however the menus were not displayed in a 'dementia friendly' manner as they were small, hand written and on blackboards in dining areas away from the areas people spent time in. When we asked people and their relatives what was for lunch no one could tell us.

Staff were observed to be calm and patient when encouraging people to the dining tables at mealtimes. Some people repeatedly left the dining area and staff calmly returned them, however the dining area close to the kitchen was busy and loud at times which unsettled some people. People were offered choices for their meals including dessert. Drinks were pre-set on the tables and condiments were offered. We noted one person did not want to enter the dining room and was very vocal about this. Two staff escorted him to a quieter area.

At the end of the mealtime we observed there were many drinks left in the glasses, two people only ate a small portion of their meal; however they were then offered soup, which they ate and one person was removed from the dining table having not had a dessert due to a different member of staff attending to them. The cook on duty told us, "I go round every day and ask people what they want for lunch, most of them forget though. I have changed all the menus. I guess what they don't like from the waste food that is returned. I will cook anything the residents ask for."

One person remained sat at the dining table from 12.40 - 15.00 after they had finished their meal, they appeared asleep and mucus was running from their nose. Staff had not attempted to assist the person to a move comfortable area of the home. However, just before staff was alerted to this, they were approached with a hot drink and made more comfortable.

On the day of the inspection there were people attending training from other homes in the Hermes group

who were coming through for drinks, walking through the area where people and their families were eating their meals. One person asked "who are those strangers"? A relative commented, "There are too many people in the dining room it gets really loud at times".

All the relatives we spoke with told us their relative had regular access to a range of health care professionals including GP's, Opticians and District Nurses when they needed them, care records confirmed this was the case.

All relatives spoken with felt that all areas of the home were clean and well presented. Some commented on many planned and recent improvements.

A relative told us, "The home looks so much better these days and there are going to be some more improvements". The manager told us they had recently changed the flooring to most areas of the home to replace carpets which could be confusing and disorientating to people living with dementia. We saw there had been new bedroom doors installed and we were told people were able to choose what colour their own door would be painted to help them recognise their own rooms.

The home had plans to create quiet areas at the end of the corridors which would be themed for example a bus stop and a train station, there were further plans to build some 1970 themed shops in the courtyard, in line with the 'pub' they had already created for people to have parties and social events.

We found there was still work to be done in the home in terms of sign posting to help people living with dementia find their way around the home, and there had as yet been no personalisation of the entrance to people's rooms for example photographs or reminiscence boxes containing familiar items which people could recognise.

Requires Improvement

Is the service caring?

Our findings

People told us, "The staff are so good to us", "There are plenty male staff, that's what I prefer" and "You couldn't want for a better group of staff to look after you".

Relatives said, "Me and my family can rest assured [relative] is well cared for", "There are two members of senior staff; they make my [relative] laugh. He loves them, it means so much" and "I have every confidence [relative] is getting the care they need"

W observed positive interactions between people who lived at the home, their relatives and staff throughout the day. Staff were kind, caring, considerate and patient when supporting people in the home. Staff did not rush people when they assisted them from one room to another for instance. Staff and people who lived at the home were comfortable together, and there was a lot of laughter and friendly 'banter' between them. People told us they got on well with staff and said, "They know just what I like", "The night staff are lovely" and "The helpers who look after me are wonderful". We observed relatives and visitors were also welcomed in a friendly manner. The manager was very hospitable towards visitors offering them drinks etc. Relatives said, "I come every day, so I get a good idea of what's going on. The staff are great", "They work so hard to keep [relative] happy, especially the activities person" and "The staff here are absolutely marvellous".

We saw that whilst in some ways staff were respectful and protected people's dignity by knocking on their bedroom doors and waiting for a reply before entering for example. In other aspects people's dignity was not protected. We noticed there were a number of people who did not have shoes or slippers on and one person who only had one slipper and not everyone was seen to be wearing clean clothing. Some of the marks were from their first meal of the day and their lunchtime meal later in the day. We found from people's care plans they were prescribed glasses, yet they were not wearing glasses, we asked staff why this was. Staff told us "the majority of people wear glasses, but they lose them so we stop bothering". We discussed this with the manager as we were concerned that this was depriving people of their ability to see clearly and increasing the risk of falls as well as a failure to protect their dignity.

We observed during the service of lunch a General Practitioner visited the home and proceeded to examine a person at the dining table whilst they (and others) were eating their meal. This disruption to the person's meal was not challenged by any of the staff who were on duty nor was it suggested that the person be taken to a more private area to protect the privacy or dignity of the person concerned. We discussed this with the manager who told us they would ensure this did not happen in the future.

This was a breach of regulations 9 person centred care and regulation 10 dignity and respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the care files we reviewed we did not see any evidence that people had access to an independent advocate or that there was a family member who was able to advocate for them in the form of a power of attorney. An independent advocate is a person who supports people who may lack the capacity to make their own decisions without support, and ensures the persons thoughts and preferences are expressed.

We found there was no content in the care plans which reminded care staff to encourage people to remain independent, and we did not see people being encouraged to help themselves during the inspection.

We saw there was some records relating to people's wishes for the end of their lives, however this was not detailed and in cases where people were living with dementia there had not been discussions held and recorded with their relatives to gain this information. There were people living at the home who were approaching the end of their lives, and the lack of detail in their care plans meant care staff would not know what their preferences were.

Requires Improvement

Is the service responsive?

Our findings

People told us, "The pub lounge is great they held a lovely party for me", "I love the singers and entertainers that come in" and "There is loads to do, I join in with anything".

Relatives we spoke with said, "[Activities person] tries to involve us in everything, she is always asking us for ideas", "The activity person has made a big impact on my [relative] and has helped her settle in well" and "All the activity people work so hard".

We reviewed the care files for six people who lived at the home. We found care plans were not up to date and did not always reflect current needs of the people they referred to, for instance where a person had deteriorated and now needed the use of bed rails this had not been reflected in their care records however there was an assessment relating to the use of the equipment. We found the care plans were not person-centred and they lacked detail about people's lives and histories. There was little evidence of people's preferences, likes and dislikes recorded in their care plans.

We found there was contradictory and conflicting information in the various sections of people's care plans, for example there was reference to a person requiring their medicines to be administered covertly, however this had not been necessary for a prolonged period of several months, the care records had not been updated to reflect this change. There was another example where a person had previously displayed behaviour that was challenging to others, however this had ceased some months before and the care records had not been updated to show their current needs.

We found that whilst there had been entries recorded each month in the review section of people's care plans, these stated, 'care plan still valid' and 'care plan remains valid'. We found instances where people who were unable to mobilise without full assistance were referred to as 'independently mobile' in some parts of their care records. This meant that care plans did not reflect the needs of people who lived in the home, and care plans were not reviewed and updated to ensure they described the current needs of people and the support they required.

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

We observed there was an activity coordinator working with people throughout the day of the inspection. We saw there were a range of activities taking place and people told us, "[activity worker] is always asking us what we want to do" and "I like bingo we have a good laugh". Another person told us, "We don't get a church service any more, I used to like it". Relatives were very positive in their feedback about the activities on offer and the impact they had on their loved ones lives. Relatives said, "[Relative] has really come out of himself. They really benefit from the activities", "They organised a brilliant party for us, the buffet was fantastic" and "The activities person is lovely, she works so hard". We saw activities included Coffee mornings, various entertainers, arts and crafts, pie and pea suppers, 'dementia friendly' tea dances at a local theatre, hand and arm massages, shopping trips and pub lunches. On the day of our inspection relatives were planning Easter

events and the making of 'Easter bonnets', relatives had brought in the materials they were donating to the event. We also observed care workers actively sitting with people and chatting.

We reviewed the complaints records. We found there had only been one complaint recorded. This had been investigated and responded to appropriately. People and their relatives were clear they knew how to complain and people's comments included, "I always say it like it. I would say if I wasn't happy" and "I would tell [senior carer] if anything was wrong". Relatives said, "[Relative has no problems, but I would pop in a see the manager, his door is always open", 'We have complained, we contacted CQC, the management here dealt with it" and "I will always make sure [relative] is safe I would stop at nothing in complaining".

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection; however there was a manager in post who was intending to register with the Care Quality Commission and was just starting the process of registration. People and their relatives told us there had been a number of managers in the past; however everyone was very positive in their feedback about the current manager who had been in post for two months, but had worked in the home in another role prior to becoming the manager and the changes they had made in the short time they had been in post. Comments received included, "There have been so many improvements since the new owners took over, long may it continue" and "This home is run well the residents, including my [relative] are really challenging"

People told us, "I love the manager, he comes and asks me every day how I am" and "The manager is smashing, he is so friendly".

Relatives were equally as positive and said, "The manager made himself known to us as soon as we arrived"; "The management are marvellous; nothing is too much trouble" and "I do hope the management has settled down". Relatives told us they felt the home was recently improved and had 'settled down'.

There was a team of staff in the home some of whom had been working there for a very long time (18 years in some cases). Staff were positive about working at the home and told us, "I love working here. I have been here eighteen years"; "I think we have a great staff team. We help each other and pull together" and "Things are definitely better since the home changed hands".

There was clear leadership evident in the home. The manager was visible and staff described how they 'led by example'. The senior care staff were clear what their roles and responsibilities were and told us they knew what aspects of their roles could be delegated to other members of the team.

The manager and all the staff we spoke to told us they all worked as a team and we observed this throughout the day we spent at the home. Staff communicated well with each other and with people and their relatives to ensure people's needs were met.

We spoke with two visiting health professionals as part of the inspection. Both health professionals told us there had been a very positive change to the home since the current manager had been in post. They described how approachable and open the manager was and that the communication and partnership working was much improved.

We saw the organisation had a suite of policies and procedures, relating to all aspects of the service provision, these policies were clear, accessible and robust.

We looked at the processes and procedures which were in place to monitor the quality and safety of the service. We found that whilst there were some processes in place to monitor aspects of the home's performance, these were not effective and had not identified the issues which were found by us. For

example the medicines audit did not included checks of physical stocks of medicines compared to the medicine administration records, neither did the audit look at the recording which was taking place and had failed to identify the incorrect and inconsistent recording of medicines administration which was evident during the inspection.

We noted there had been 'visits on behalf of provider' checks carried out periodically, however these reports had not identified some of the concerns found during inspection, and where there had been issues raised there was little evidence that action had been taken to rectify the issue or that the actions had been followed up to ensure their completion. This meant the registered providers had a low level of oversight of the service as key issues were not being recognised.

We found the standard of records was not always adequate. Daily care records were not detailed and did not allow the reader to gain any insight into how the person about which they were written had spent their days. Daily care records are very important as they are the only records which would give a general practitioner for example information about how a person presented over a period of time, which could be critical to diagnosing a condition.

We found the registered provider had not ensured clear records of the maintenance of the building and equipment were easily accessible for us to confirm this was in place and up to date.

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

We noted prior to the inspection that we had received a very low number of statutory notifications. A Statutory notification is a report sent to the Care Quality Commission informing us of incidents which affect the running of the home or the people who live there, for example when people die, or there are any safeguarding concerns. We found there was evidence there had been safeguarding concerns which had been reported to the commissioning authority, however the registered provider had failed to inform us in line with the requirements of their registration. We discussed this with the manager who demonstrated their understanding of the events they would need to notify us of, and assured us they would make all necessary notifications.

This was a breach of Regulation 18 notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

We spoke with people and asked if there had been any meetings which they could attend to share their thoughts and feedback on the home, people told us, "I once went to a meeting, I have not bothered anymore" and "There have been no meetings since I have lived here. It would be good"

Relatives we spoke with told us there had been no opportunity for them to attend meetings with the management or owners of the home. Relatives said, " If there were meetings with relatives, then I would definitely go" and "We have not been asked our views and opinions since [relative] has been here". We noted there was a meeting advertised for later in the month

We asked to see recent quality assurance records, the administrator told us there had not been any questionnaires sent out for 'a long time', although we were told they were in the process of sending out surveys to people. People and their relatives had differing experiences of feeling involved in the running of the home, with some people feeling involved and others telling us they were not at all involved.

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 18 Registration Regulations 2009 Notifications of other incidents The provider was not informing the commission of safeguarding matters which had been reported to the Local Authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care care plans were not person centred and contained contradictory information in some cases. Staff knew people well and whilst the care plans did not reflect the current needs of people, we saw that people were being cared for and their needs met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People did not have shoes or slippers on, people who should have been wearing glasses without them, and one person left at the dining table for a lengthy period without attention

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There were not always MCA carried out and we did not see evidence of consent to care being gained. It was the opinion of the manager that none of the people in the home would have

capacity to give their consent. We did not see evidence of POA's or BI decisions in most of the files we looked at and where there had been a BI it was not in relation to decisions about their care and treatment or where they lived. There were issues with the use of covert medicines as the correct process had not been followed and there were no plans to show what had been agreed and under what circumstances this should be applied

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents had not been recognised as safeguarding and had not been reported as such for investigation We identified some people not having pain killing medicines, there was no record of why this was, there was no evidence this had been reported to anyone for follow up.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider failed to provide certificates to show the building was maintained correctly.

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 Staff did not all have up to date training. Staff were not receiving appraisals although they were being supervised.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not risk specific and did not show the measures which needed to be in place to keep people safe. One person had bedrails for which there was no risk assessment in place. Medicines were not always managed safely as there was poor recording on MARs and some of the stocks checked did not match the records

The enforcement action we took:

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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 processes which were in place to monitor the safety of the service were not effective as they did not identify the issues found during the inspection as the audits were not detailed enough and there was little evidence of any actions being taken or checks made on whether actions had been completed. Records were not detailed and did not reflect the care and support which had taken place

The enforcement action we took:

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