High Trees Care Limited

River View Care 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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

River View Care home is a large nursing home in Dartmouth which is registered to provide accommodation for up to 80 people who require nursing or personal care. The home provides care for older people, people living with long term health conditions and people living with dementia or mental health needs. At the time of the inspection people's care was being delivered on two floors. The first floor accommodated people who suffered with advanced dementia. People who required nursing care were accommodated on both the ground floor and the first floor.

This inspection was unannounced and took place on 26 August 2015. At the time of our inspection there were 34 people living in the home, nine of those required nursing care and 11 were living with dementia. Previous restrictions on admitting people had been placed on the home by the local authority and further restrictions were placed on the home following our inspection. The home's accommodation was set out across four floors but only two of those were in use due to the number of residents living there.

Summary of findings

There had been no registered manager in post since June 2015. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a manager in post who was not registered with the Care Quality Commission (CQC).

People were not always being protected from risks associated with their care and treatment. Risks were not always identified and actions were not always taken to ensure risks were minimised and people were safe from harm. Steps were not taken to ensure appropriate management plans were in place in relation to people demonstrating behaviours which could pose risks, leaving people at risk from others and from themselves.

Recent changes to the staffing levels had impacted on medicine rounds which were taking a very long time. This meant people were not always receiving their medicines at the times prescribed. We have made a recommendation around staffing levels in the home.

The manager had taken steps to improve the quality of the food people were provided but staff could not assure themselves that people were having enough to eat and drink because of a lack of oversight and records. One relative we spoke with said "If I wasn't here I don't have confidence (relative) would get enough fluids and food". Buffet style food as well as hot meals were available throughout the day and night for people and during our inspection we observed some people in the dementia unit being prompted and supported to eat by staff sensitively.

People spoke very highly of the staff and their caring attitudes, however relatives and staff expressed concern at the fact people were only getting their basic needs met. One relative said "There is not much imagination towards improving people's quality of life. They take care of basic needs but nothing further". Another relative said "I have observed changes in the emotional wellbeing of the residents. There aren't enough people interacting with them". People's confidentiality was not always maintained as personal records were located in areas that were readily accessible to anyone in the home.

Staff displayed patience and kindness towards people in the home. We observed some very pleasant interactions with people and saw staff speaking to people in a respectful manner. Staff had undergone thorough recruitment processes and were provided with training and regular supervision.

Care plans did not always accurately reflect people's needs. Where people's needs had been assessed these were not always being responded to. People's care plans did not always contain personal information which would enable staff to care for them in a personalised manner. Care plans lacked information and guidance relating to the person's dementia and the management of behaviours that may present a risk to people. We did however observe staff competently redirecting people, providing reassurance, comfort and supportive interventions. People's social and emotional needs had not always been fully assessed and care plans had not been developed to ensure these needs were met. People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing and there was little activity or stimulation available for people.

There were no systems in place to audit people's care plans. Care plans had not been regularly updated or reviewed and one person did not have a care plan in place.

There was an effective system in place to manage complaints or concerns about the service. People and relatives told us they felt comfortable raising concerns or complaints. One person said "The manager tells me off in a nice way if I don't tell her if something is bothering me".

There was a lack of systems in place to assess and monitor risks to people. The systems in place to ensure people were receiving appropriate care and that risks were being identified were not effective. There was a lack of oversight of people's care which potentially put people at risk.

The systems in place relating to quality assurance had not identified some of the concerns we found during our inspection. Staff did not always know their responsibilities in relation to overseeing people's care. Neither the staff nor the manager felt adequately supported. The manager told us they promoted an open and transparent culture. They told us they encouraged

Summary of findings

people to feedback and raise concerns. People and their relatives confirmed this, however, they felt the lack of communication from senior management did not demonstrate openness.

Relatives and people spoke highly of the manager. They said “I like (the manager) she’s marvellous”, “The manager is doing the best she can”, “The manager wants to get it right”, “This is the best manager we’ve ever had”.

We found a number of breaches of regulations and you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People were not always being protected from risks associated with their care and treatment.

People were put at risk of harm due to appropriate management plans not being put in place in relation to people who demonstrated behaviours which could pose a risk.

Staffing levels were not adequate to meet people's needs.

People did not always receive their medicines at the times prescribed due to long medicine rounds.

Is the service effective?

Requires improvement

The service was not always effective.

One person's risks of malnutrition and dehydration had not been effectively assessed, monitored and reviewed.

Mental capacity assessments had not always been completed and there was not always clear guidance in care plans around obtaining people's consent.

Staff received regular training, supervision and appraisal.

Appropriate applications had been made in relation to Deprivation of Liberty Safeguards.

Is the service caring?

Requires improvement

The service was not always caring.

People's confidentiality was not always maintained.

People were only receiving basic needs that did not ensure emotional well-being.

We observed some very pleasant interactions with people and saw staff speaking to people in a respectful manner.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans did not always contain personal information which would enable staff to care for them in a personalised manner.

People's social and emotional needs had not always been assessed or met.

People did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing.

Summary of findings

There was little activity or stimulation available for people.

There was an effective system in place to manage complaints or concerns about the service.

Is the service well-led?

Requires improvement

The service was not always well led.

There was a lack of systems in place to assess and monitor risks to people.

There were no appropriate systems in place to ensure people were receiving appropriate care.

There was a lack of oversight of people's care which put people at potential risk.

The systems in place relating to quality assurance had not identified some concerns found during the inspection.

People and their relatives thought highly of the manager and believed they wanted to make changes for the better.

River View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection visit took place on 26 August 2015 and was unannounced. This inspection was carried out by two adult social care inspectors and one specialist advisor, who was a nursing professional with experience in treating people with dementia. Prior to the inspection we reviewed the information we had about the home, including notifications of events the home is required by law to send us.

During the inspection we spoke with the manager, three registered nurses, six care staff, one maintenance staff and a visiting district nurse. We also spoke with eight relatives of people who lived in the home.

We spoke with six people who lived at River View Care Home. Most people who lived on the first floor were unable to verbally communicate with us and we therefore used the Short Observational Framework for Inspection, or SOFI. SOFI is a specific way of observing care to help us understand the experience of people who could not communicate verbally with us.

We looked in detail at the care provided to seven people, including looking at their care files and other records. We looked at the recruitment and training files for five staff members and other records in relation to the operation of the home such as risk assessments, policies and procedures.

Requires improvement

Is the service safe?

Our findings

People were not always being protected from risks associated with their care and treatment. We identified concerns in relation to the assessment and management of risks, lack of action taken to manage risks to people's health and welfare and staffing levels.

Risks were not always identified and therefore actions were not taken to ensure risks were minimised and people were safe from harm. One person had been diagnosed with diabetes. The GP had given instructions for this person's blood sugar levels to be taken twice a day and had instructed that the acceptable range for their blood sugar levels should range from six to 10 mmols (this is a unit of measurement relating to blood sugar levels). This person's care plan contained instructions for the GP to be contacted for advice should the person's levels fall outside of that range. Records showed that on eight occasions within five days during the week prior to our inspection the person's levels fell outside of the range and at its highest their blood sugar level was 27.2 mmols. There was no record of any action being taken to address the height of these levels. The GP had not been contacted and no plan had been put in place to ensure levels returned within their agreed range and safeguarded this person from risk. Staff we spoke with had not identified the person's blood sugar readings as being a problem and had therefore not taken any steps to protect the person.

Steps were not taken to ensure appropriate management plans were in place in relation to people whose behaviour could put themselves, or others, at risk of harm. For example, one person had a behaviour assessment within their care plan. This had last been completed in July 2015 and stated their mood was usually calm. Within the month of August, however, there were 12 incidents where this person had displayed aggression towards other people living at the home, staff and themselves. These included a number of physical assaults. This person's care plan had not been updated to reflect this change in behaviour and no measures had been put in place to protect the person, other people living in River View Care Home or staff from this behaviour. These incidents had been recorded in the person's behavioural assessment forms but had not been analysed by staff or management. The staff and management acknowledged there were issues with this person's aggressive behaviours but were unable to tell us of any plans that had been put in place to protect people at the time of our inspection.

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

Staff had undertaken training in safeguarding. Staff understood what to do if they identified concerns and told us they felt comfortable raising any concerns. We looked at the service's safeguarding policy as well as their whistleblowing policy. We saw details of external agencies to be contacted and their contact details. We found, however, that this policy was not always being followed.

Following our inspection the manager made alerts to the safeguarding team in relation to incidents we had identified. Prior to our inspection appropriate referrals had not been made as the incidents had not always been reported to the manager as per the home's policy. Although the home had systems and processes in place to protect people these had not been operated effectively. This meant people were at risk due to staff not identifying potential safeguarding incidents.

A recent change in staffing had been made at the home. Nurse numbers had been reduced from one on each floor to one for both floors. In order to continue to ensure people received their medicines, senior care staff had been trained to administer medicines alongside the nurses. The nurses administered medicines to people who required nursing care and the senior care staff administered medicines to those who received personal care. The morning medicine round took a very long time on the day of the inspection (four hours). We spoke with staff who told us medicine rounds were taking a very long time on a regular basis due to the recent changes in staffing. This was due to staff who administered medicines needing to travel between floors during the medicines rounds and take part in hands on care. This meant people were not receiving their medicines at the times prescribed and were not always receiving pain relieving medicines at the time required. For example, on the day of our inspection one person required their medicines to be administered one hour before food or drink in order to make the medicine work effectively. This person was due to receive this medicine early in the morning in order for them to be able to eat breakfast at a

Is the service safe?

reasonable time following them taking this medicine. Due to the length of time required for the medicine round, by the time they were administered their medicine they had already drunk a cup of coffee.

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

Staff understood how the systems for the safe administration of medicines worked and had received appropriate training and assessment of competency. A recent audit of medicines had been carried out. Medicines Administration Records (MAR) were appropriately completed. We observed staff administering medicines and found correct procedures were followed. Best interest decisions had been made following assessments of capacity where people were no longer able to make decisions about taking their own medicines.

Staff, relatives and people who used the service did not feel there were sufficient staffing numbers to meet people's needs. Four members of staff told us they felt there were not enough staff to care for people well. They told us the staffing numbers did not enable them to carry out their role effectively and to have oversight of people's needs. They said "People are not always being well cared for", "I don't think we can always meet people's needs"; "We're having to make people wait because of staffing" and "There are not enough staff, it is difficult to have oversight of people's needs".

These views were shared by five relatives we spoke with. One relative said "There doesn't seem to be enough staff to carry out the proper care". They told us their relative was reluctant to be assisted to a chair or to their bed during the day as they felt there would not be enough staff to assist them back when they wanted. Other relatives said "They are always very pushed, people are very fragmented and that leads to sloppiness and communication is missed", "They are overworked and I don't think they have time to review records", "There is a lack of staff, sometimes it can feel like there is nobody here", "They're short of staff, there's not enough staff, the staff numbers are not good. The care is impacted as they just haven't got the time" and "there are inadequate numbers of staff on the floor". One person who lived in the home said "Very often there are only two on and I think there should be more than two".

One relative we spoke with described an incident, which had occurred two weeks prior to our inspection, whereby their relative had been left in soiled clothing for a long period of time. This relative told us they had attended personally to their loved one's personal care as they were unable to find a member of staff. Another relative told us their relative's hair had not been washed for a very long time, they said "I can't remember the last time they washed her hair". They told us this had happened due to the changes in staffing numbers.

The manager told us the staffing numbers for the home were seven care staff, including a senior member of care staff and one nurse during the days and one nurse and four care staff during the nights. We looked at the staff allocation sheets for the week of our inspection and the week prior to our inspection and found three occasions when the staffing levels fell below those numbers. On one occasion there were four care staff and one nurse during an afternoon shift. There were 12 people living on the ground floor who required two members of staff to tend to their moving and handling needs as well as six people who required staff assistance with eating and drinking. Staff said the staffing levels had been inadequate and people had not received appropriate care during those periods. The manager told us the home used a staffing model which was based on the number of people and their level of dependency. The manager told us the staffing levels were adequate for up to 36 residents according to the staffing model. The manager said "I think the staff struggle, I think it's a tall order". It was the view of people we spoke with, staff and relatives that staffing numbers were not adequate to meet people's needs.

We recommend that the service review their staffing numbers in relation to the specific needs of the people living in River View Care Home.

People were protected from the risk of unsuitable staff because the service had appropriate recruitment systems in place. The service had taken steps to ensure staff were of good character, and had appropriate skills, knowledge and qualifications to carry out their role.

Requires improvement

Is the service effective?

Our findings

We identified concerns in relation to the monitoring of people's food and fluid intake, and involving people in making decisions about their care.

During our inspection we identified one person at risk of malnutrition and dehydration who had not had their care effectively assessed, monitored and reviewed. This person had been weighed weekly for a period of several months due to having been identified as being at risk. Records showed that over a period of one month they had lost a significant amount of weight and were at times finding it difficult to eat or drink. No action plans had been put in place to manage this person's weight loss and there were no recorded instructions for staff in relation to ways of increasing this person's intake. The person had been admitted to hospital two weeks prior to our inspection suffering with dehydration and had spent three days in hospital. There was no evidence staff had made efforts to increase this person's fluid intake or raised the person's low intake as a concern for their health. This person's failing health had been identified by their relative and not by the staff. They said "Nobody had picked up that he was losing weight". On return from hospital the person was weighed and had lost further weight. No changes had been made to the person's care plan to reflect the new weight loss or the admission to hospital and there were no risk assessments or management plans in place to minimise the risks relating to this person's weight or risks of dehydration. Fluid intake charts relating to the day prior to our inspection showed this person had only consumed 400ml of fluids and their identified target intake was 1446ml. There was no evidence this had been identified as a concern and the GP had not been contacted in relation to this. There was no guidance for staff on how to encourage this person to eat and drink and avoid them losing more weight or becoming dehydrated.

Where people had been identified as being at risk of losing weight we found staff had not always recorded the food and drinks they had given to people but not how much of it had been consumed. This meant it was not possible for staff to ensure people had had enough to eat and drink..

One relative we spoke with and a visiting healthcare professional told us people appeared thirsty. The relative said they came into the home every day to visit their relative and feed them as they had no confidence the home would provide adequate fluid and nutrition to their relative. They said "If I wasn't here I don't have confidence (relative) would get enough fluids and food" and "I don't think there is enough fluid intake".

One member of staff told us people who required assistance with drinking were not getting as much as those who were independent as the staff did not have time to ensure they drank adequate amounts.

This is a breach of Regulation 12 (1) (2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The Mental Capacity Act (2005) (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

There was not consistent evidence across care plans that efforts had been made to involve people living in the home in making decisions about their care where they had the capacity to do so. One care plan we looked at, for example, did not contain any information about the person's preferences, likes or dislikes. Another person's care plan stated they were unable to express themselves verbally at times but there was no guidance for staff relating to the different ways to approach this person in order to obtain their consent and ensure they were able to make decisions. However, we saw that staff involved people in making day to day decisions such as where they sat or what they ate. We saw people being offered menu options in ways they could understand, such as being shown two choices to select from. During staff handover we heard staff had used knowledge about a person's history to calm and reassure them the night before. Staff we spoke with knew people well and could describe their needs as well as their preferences. We asked staff how they knew people's needs and preferences and they told us they gained this knowledge by speaking and spending time with people.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This includes decisions about depriving people of their liberty so that they get the care and treatment they need, where there is no less restrictive way of achieving this. The manager told us several applications had been made with regard to DoLS where they had identified people's liberties were being restricted.

Requires improvement

Is the service effective?

Staff told us they received regular training at the home. Staff had received a number of training courses including a basic awareness course and foundation course in dementia. Staff had also been given supervisions and appraisals and had been encouraged to share their views during these. Further training and qualification opportunities were discussed during these meetings.

People had been referred to outside healthcare professionals including GPs, mental health practitioners and physiotherapists. The manager told us about the advice the home had sought from professionals in order to better care for people who were at the end of their life.

The manager had identified that improvements were required in relation to the food provided at the home. They had taken steps to implement change. People told us the food had improved. One person said "The food is acceptable but not exciting". Another person said "The food is good but it has been awful in the past". Another person said "The food is improving". The manager told us that one change they had implemented involved making satisfying food available throughout the day and night. They told us some people who lived with dementia were confused about time and therefore they had arranged for full meals to be available for people at whatever time they would like them. They told us the chef prepared buffet style food for people to enjoy throughout the night if they wanted as well as hot meals.

Some people in the dementia care unit needed support and prompting from staff with their meals. We saw that this was done sensitively. Some relatives also attended the mealtime to support their relation with their eating and drinking. Efforts had been made to make the dining room a calm environment where people could focus on eating, free from additional distractions. Staff were available to guide and prompt people and encourage them back to finish their meal if they left the table.

Requires improvement

Is the service caring?

Our findings

People spoke very highly of the staff and their caring attitudes, however, relatives and staff expressed concern at the fact people were only getting their basic needs met.

Staff told us they respected people's privacy and dignity, however, daily records were left in communal areas. All visitors and relatives could have access to them, without the person being aware. This showed a lack of respect for people's privacy and confidentiality.

Relatives told us they felt people's basic needs were being seen to but nothing more than that. One relative said "There is not much imagination towards improving people's quality of life. They take care of basic needs but nothing further". This relative became upset when speaking with us and told us their relative was becoming more and more down in their mood. They said "My (relative) just needs to be given care and understanding. Time is not spent on understanding and caring for her". Another relative said "I have observed changes in the emotional wellbeing of the residents. There aren't enough people interacting with them". Staff also told us people were just receiving their basic needs and no more. People's well-being and self-esteem needs were not being met. Staff told us they did not have time to spend time with people or to meet all their choices and preferences.

Staff displayed patience and kindness towards people in the home. We observed some very pleasant interactions with people and saw staff speaking to people in a respectful manner. We observed one member of staff offering a person nice supportive intervention which boosted their sense of wellbeing.

People we spoke with spoke highly of the staff and said "They're very good here, if you want anything they do it for you", "They're so helpful", "People are very kind" and "They are all very nice, very friendly". Relatives we spoke with said "If you can find staff they are very nice" and "They really care", "The staff are very sweet, very nice".

We observed staff speaking respectfully to people. When we asked a person if they were always spoken to in a respectful manner they replied "No problems there at all".

Requires improvement

Is the service responsive?

Our findings

Some people did not have up to date records. For example, some people's care plans did not always contain personal information which would enable staff to care for them in a personalised manner. People's social and emotional needs had not always been fully assessed and care plans had not been developed to ensure these needs were met. Care plans lacked information and guidance relating to the effects of dementia on people and the management of behaviours that could put people at risk. For example, one person living with dementia had no dementia care plan and only very brief information about their memory loss. There was no information about the person's strengths or retained skills and how to support them to keep these.

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

There were 11 people living with dementia on the first floor. These people did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. Care plans did not always contain personal information about their interests, likes and dislikes and where these had been included there was no evidence this information was being used in their day to day lives to develop individual ways of stimulating and occupying them. For example, we saw one person's file contained clear information about their life prior to coming into the home, their likes and interests. We could not see any evidence however that this was used to improve their experience in the unit.

We observed how people in the first floor dementia care unit spent their time. There was little activity or stimulation available or organised for people. There was a 'rummage box' available in the dining room with items for people to engage with. However people were not directed to this and staff did not help them to interact with the items, such as games and books, so they were not used. One person read a newspaper, but no-one was available to sit with them and discuss what they were reading. Many people spent their time pacing the corridors, or looking for a way to leave. Two staff we spoke with told us they were not sure about the input from the activities staff, or when it was provided for people. However one told us "I try to make everything an activity" and another said "We go with the flow. Sometimes we use music to help calm and support people, for example over supper". This showed us that staff were trying to find activities or stimulation that were helpful and supportive to the people they were caring for.

The lack of personalisation in people's care plans and people's preferences not always being used to plan their care was a breach of Regulation 9 (1) (a) (b) (c) (3) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

One person who lived on first floor and living with dementia was causing distress to others with their behaviour. Staff had not taken any caring action to ensure people's wellbeing was not impacted. For example one person was very distressed by an incident where the person had shouted at them at close range. It was some time before staff were available to comfort this person, which had left them tearful and anxious.

We observed some very good interactions between staff and people who lived in River View Care Home. For example, one person living with significant dementia was interacting with and deriving comfort from nursing a doll. Staff complimented the person on how well they were doing this and the person smiled and hugged the doll closer. Staff gave people patience and support and there were instances where staff demonstrated good practice in diffusing situations. We observed staff competently redirecting people, providing reassurance, comfort and support.

There was an effective system in place to manage complaints or concerns about the service. People and relatives told us they felt comfortable raising concerns or complaints. One person said "The manager tells me off in a nice way if I don't tell her if something is bothering me". The manager told us all staff were told about the grievance process and policy and were encouraged to make complaints where they had concerns.

People and relatives told us they felt comfortable making complaints. A relative's forum had been created and the manager met with the forum regularly in order to discuss any concerns they had.

Requires improvement

Is the service well-led?

Our findings

People and relatives spoke highly of the manager but expressed concerns over the decisions taken by senior management, the lack of communication, the staff shortages and the oversight of the home.

There was a lack of systems in place to assess and monitor risks to people. Although the home did not have a clinical lead to oversee care and treatment, the manager reported robust systems were in place to recruit to this position. Whilst this position was not filled, however, there weren't appropriate systems to ensure people were receiving appropriate care and that risks were being identified. The manager was not a nurse and relied upon the nurses to oversee clinical care, however, the nurses reported that because they had not been told to and because of lack of time they were not doing this. Staff were recording aspects of people's care, such as weights, blood sugars and fluids, but were not reviewing these records in order to identify risks to people. Appropriate systems were not in place to identify this lack of oversight of people's care or set up systems to mitigate any risks to people.

There was a lack of robust systems to ensure record keeping was sufficient to keep people safe. Records were not always accurate and maintained. For example, one person had been living in the home (receiving respite care) for six days at the time of our inspection. The only documentation available for this person was a medicine risk assessment and some daily update sheets. A care plan had not been created and there was no pre admission assessment or other risk assessments. Within the person's daily records there were two entries relating to a pressure ulcer staff were monitoring. There was no evidence relating to how or when this person developed the pressure ulcer, no body map detailing its location, no measurements and appearance of the sore and no evidence of how staff were managing and preventing deterioration of the sore. We spoke with the manager about this person's skin integrity and they told us they were unaware this person had a pressure ulcer.

The systems in place relating to quality assurance had not identified some of the concerns found during our inspection. There was no internal system for assessing the quality of the dementia care within the home and the manager had not sought any best practice guidance in this area. Staff told us they knew how to care for people with dementia from their own experience and not from instructions given to them whilst working at the home.

The manager at the home had not been supported in her role. The manager told us about an incident that had taken place the week prior to our inspection. The nurse who was due to work the night shift was unable to attend. Medicines needed to be administered to people receiving nursing care during the night and therefore a nurse or a trained senior member of staff was needed during the night shift. The manager made contact with staff as well as local agencies in order to find a nurse to work the shift without any success. They had contacted their manager for support and were told there was no contingency plan in place for such situations and the manager was to stay at the home to provide cover. The manager is not a nurse and did not feel confident or supported to do this. The manager told us they had not received any formal supervision.

Staff we spoke with did not feel supported by the manager and displayed low morale, one member of staff said "We are not being supported and the manager is not being supported". The staff did not always demonstrate good team working and there was unclear management structure, with no clearly defined member of staff responsible for care oversight. Staff had not always reported incidents to the manager due to this expressed lack of confidence in the management and this in turn meant the manager had no had oversight of incidents. This led to problems in communication, staff not being clear about their responsibilities, appropriate actions not being taken and the home's systems not always being followed.

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

People and relatives spoke highly of the manager, they said "I like (the manager) she's marvellous", "The manager is doing the best she can", "The manager wants to get it right", "This is the best manager we've ever had" and "The manager is trying really hard". One person said "The manager comes to see me most days, she asks me for feedback".

The manager told us they promoted an open and transparent culture. They told us they encouraged people to feedback and raise concerns. People and their relatives corroborated this and told us they were encouraged to give

Requires improvement

Is the service well-led?

feedback and felt comfortable raising complaints with the manager. One relative stated the manager listened to their opinions and was "very open". However, they felt the lack of communication from senior management did not demonstrate openness. Relatives spoke of a "cutting down in staffing numbers happening from higher up" and stated the details of this had not been shared with them. The manager told us the decision to change the staffing numbers had been made in April 2015 but they had not been made aware until a few weeks prior to our inspection. A meeting had been organised, in the week following our inspection, between the relative's forum group and the senior management in order to discuss the changes.

Various audits and checks had been carried out but these were not all completed regularly. It was evident that some steps were being taken to address issues in the home but many of the issues identified at our inspection had not been recognised or acted on.

Following our inspection steps had been taken to provide support to the manager and respond to the issues we had identified. A temporary manager had been appointed at the home to provide support and assist in reviewing people's care. A staff meeting and a relative's meeting had been organised in order to improve on communication and specific concerns relating to people's safety had been acted upon.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person had not appropriately assessed risks to the health and safety of service users or done all that was reasonably practicable to mitigate risks. People were not protected from the unsafe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How this regulation was not being met: People's care did not always meet their needs or reflect their preferences. People's preferences were not used to design their care and treatment. Regulation 9 (1) (a) (b) (c) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Appropriate systems were not in place to assess, monitor and mitigate risks to people and appropriate records were not accurate for each person. Regulation 17 (1) (2) (b) (c)