Elder Homes Wellingborough Limited

Dale House Care Centre

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?	**Inadequate**

Summary of findings

Overall summary

Dale House Care Centre is located in Wellingborough in Northamptonshire and is registered to provide nursing and personal care for up to 66 older people, who may be living with dementia and have other associated care needs. At the time of our inspection, there were 41 people living at the service.

We carried out an unannounced comprehensive inspection of this service on 22 December 2014 and rated it 'Good'. On 06 November 2015 we carried out a responsive inspection following information of concern which was received by the Care Quality Commission. These concerns were in relation to pressure care and the diet and nutrition of people using the service. We were unable to substantiate them, therefore there were no changes to the rating of 'Good', and no breaches of regulation were identified.

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

We carried out our second unannounced comprehensive inspection on 26 February and 01 March 2016. Prior to this inspection we had received concerns in relation to the care people were receiving and the management of the service. In addition, we learned that the service had gone into administration and therefore needed to ensure that people's care would continue to be delivered in line with the fundamental standards.

The service did not have a registered manager. 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. In the previous year, the provider had appointed a manager who was due to register with the Care Quality Commission; however they left the service without progressing their application. The area manager assumed the role of managing the service, however they also planned to leave the service; with their last day being the first day of our inspection.

The administrators had appointed a care management company to assume management of the service, whilst it was in administration. They had appointed a peripatetic manager to lead the service until a new registered manager had been appointed.

The provider had failed to ensure there was effective quality assurance and audit systems in place at the service. There was no effective oversight of the service, or the quality of care people were provided with. The checks implemented failed to identify safety concerns, or the specific care needs of the people living at the service. Risks to people receiving care had not been appropriately assessed and acted upon by the provider. There was a negative atmosphere amongst staff at the service which meant that the care provided was not always the best it could be. Staff members did not feel well supported by the previous manager and the provider, and were concerned about the future of the people who lived at the service and for their job roles as the service was in administration.

Safeguarding incidents at the service had not been managed appropriately.People felt safe at the service and we found that incidents relating to safeguarding people had been reported to the provider by members of staff; however they had not been reported to the appropriate external organisations. This meant that there were ineffective measures in place to protect people should they be subjected to abuse.

Risks to people and the environment had been assessed, however they were not user friendly and did not provide staff with the information they needed to minimise risk. In addition, risk assessments did not empower people to take positive and meaningful risks whilst living at the service. Staffing levels at the service were variable which meant that, at times, people's needs were not being met. Agency staff were relied upon to cover shifts which meant that people were not provided with consistent care. People's medication was managed by the service to ensure it was given as per the prescriber's instructions.

The service did not have systems in place to ensure the principles of the Mental Capacity Act (MCA) were being followed. There was a lack of evidence to show that people had consented to their care or that decisions made on their behalf were in their best interests. Staff did not receive regular supervision or support to identify areas for development; however they did receive regular training. People were happy with the food at the service and felt that this was improving. People's nutritional needs were assessed to ensure they were met. People were also supported to see health professionals in the service or local community when required.

Due to changes to the staff team within service, and the regular use of agency staff, people were unable to build close and meaningful relationships with members of staff. People and their families did not get the information they required from the service and were not involved in producing their own care plans. People were treated with dignity and respect by members of staff, who worked to promote their privacy at all times.

People did not receive person-centred care from staff at the service. Care plans did not always provide staff with sufficient guidance to meet people's specific needs and wishes and were not user-friendly. Care plans had been reviewed; however there was no evidence to show that people or their families had been involved in reviewing them. Activities were organised by the service, however these were not specific and therefore not relevant for all the people living there. There was a system for receiving complaints, however not all the people or their families were familiar with this, or confident that they would be listened to. Verbal complaints and feedback had not been logged, and there was no evidence to show that written complaints had been investigated in full.

We identified that the provider was not meeting regulatory requirements and was in breach of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was not always safe.

There were not effective systems in place to ensure that incidents of potential abuse were reported appropriately.

Risk assessments were in place, however were not helpful and did not offer staff sufficient guidance to ensure that risks were managed safely.

Staffing levels at the service were not consistent and did not always ensure that people's needs were met.

People's medication was managed effectively by the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff members asked people for their consent, however there were not systems in place to ensure that the service was following the principles of the Mental Capacity Act 2005.

Staff members did not receive regular supervision and support to help identify training and development needs, or to raise concerns. They did receive regular training to help maintain their skills and knowledge.

People felt the food at the service was good, and that there had been recent improvements to food and drink that they were given.

People were supported to see healthcare professionals when necessary, both in the community and in the service.

Is the service caring?

Requires Improvement

The service was not always caring.

Due to a variable staff team, people were not always able to build strong and meaningful relationships with members of staff.

People had not been involved in planning their care and were not given information about the service that they received.

Staff members treated people with kindness, dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive person-centred care. Care was task-based and plans did not provide staff with personalised, specific information that they required to meet people's needs and wishes.

Activities took place at the service; however they were not based on knowledge of people's specific interests and did not take place on a regular and frequent basis.

People were not always sure about how to make complaints about the care that they received and complaints that were made were not always investigated in full.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to implement systems to ensure the service was safe and able to provide people with the care that they needed.

There was ineffective oversight over the service from the provider and management, which increased the risks of potential harm and poor levels of care at the service. Lessons had not been learned to drive improvements in the care being provided.

The service did not have a registered manager in post.

There was a negative culture amongst members of staff at the service. They felt poorly supported by management and the service going into administration had left staff feeling unsure about their future.

Dale House Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on the 26 February 2016 and 01 March 2016, and was unannounced. The inspection was undertaken by a team of two inspectors and an expert by experience on the first day, and three inspectors on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert used for this inspection had experience of a family member using this type of service.

Prior to this inspection we had received some information of concern. We therefore reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We also spoke with the local authority and clinical commissioning group to gain their feedback as to the care that people received.

We spoke with eight people who lived at the service, to find out their views about the care that they received. We also spoke with eight relatives, who were visiting family members who lived at the service. In addition to this, we spoke with 15 members of care and ancillary staff, as well as the previous manager and deputy manager. We also spoke with staff from the care management company, including the director, the new peripatetic manager and two project managers.

We checked twelve people's care records, to see if they were up-to-date and an accurate reflection of their care and support needs. We also looked at other records relating to the management of the service, including staff recruitment, medication charts and quality audit records.

Requires Improvement

Our findings

There were ineffective systems in place to protect people from abuse. Potential safeguarding incidents had not been reported to the local authority or the Care Quality Commission (CQC) by the manager of the service. We checked incident records, but only found that those reported in 2016, there were none available for 2015. These incidents had been reported to the provider, however they had not referred them on to external organisations as required and as such, it was not possible for them to investigate and take action to ensure that people were safe from avoidable harm or abuse. In addition, there was no evidence to show that potential safeguarding incidents had been analysed or used to identify trends which may indicate that abuse had taken place. This meant that people were not always protected from avoidable harm or abuse.

The peripatetic manager told us that these incidents needed to be reported, and that they would implement systems to ensure they were reported to the local authority and CQC in the future. In addition, they would review all the incident reports in the service as they carried out their re-organisation. If appropriate, previous incidents would be reported, to ensure external organisations were fully aware of what had taken place at the service.

Staff members told us that they received training in safeguarding, and were aware of abuse and the different forms that it could take. They were also aware of their responsibilities in terms of recording and reporting incidents, including incidents of potential abuse. One staff member told us, "I have had training on safeguarding, about protecting people from different types of abuse. If I suspected abuse I would report it to my senior staff member or management straight away." This showed that staff were aware of their reporting responsibilities, however incidents or concerns were not always reported on to the local authority or CQC, once staff had completed an incident report.

Systems and processes were not operated effectively to ensure that people were protected from potential abuse. This was a breach of regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were ineffective, and failed to provide staff with the guidance they required to ensure people were safe from harm. Staff members told us that they were difficult to follow, and did not always provide them with the information that they needed. One staff member told us, "Risk is assessed but they [risk assessments] aren't very good or useful." Another staff member said, "Risk assessments aren't very helpful." We saw that risk assessments were in place at the service; however they did not demonstrate an understanding of the risk assessment process, or of the necessity to provide control measures to mitigate

risk.

We found that one person had a tissue viability risk assessment in place, which gave a risk rating of 'high risk'. There was no evidence in the risk assessment to demonstrate how this rating had been determined, and there was also a lack of evidence to show the control measures that staff should follow to minimise the impact of this risk. For example, there was no information regarding specialist equipment which staff should use. We spoke to the peripatetic manager about this. They agreed that the risk assessments in people's care plans were not fit-for-purpose and said that they had plans to review each person's risk assessments, to ensure they were accurate and provided staff with the information they needed.

The service was not fully staffed, and staffing levels were not always consistent. People and their family members told us that they were concerned about staffing levels and the fact that the service had to regularly use agency workers to cover shifts. One relative told us, "The staffing at the weekend is just agency staff; they don't know my Dad at all." Another relative said, "This constant change of staff is a concern, there is often not enough staff." Staff members also told us that staffing levels at the service was a concern. They explained that they were often under-staffed, and that agency staff were regularly used to boost staffing levels. One staff member said, "Every week we are normally one staff member short." Another staff member told us about the care that one person had received. They said, "We did our best for him, because of staffing issues we didn't meet his needs."

The deputy manager told us that staffing levels were based on people's assessed needs, but did inform us that there were occasions when numbers of staff on shift did not meet the assessed levels required. They explained that there had been recent recruitment of new staff members to a number of different positions at the service, and that these staff members would be able to start at the service when background checks had taken place. Throughout our inspection we observed that staffing levels matched those on the staffing rota, however there were insufficient numbers of permanent staff to achieve this, therefore the service relied on agency care and nursing staff. We spoke to the peripatetic manager about staffing at the service. They told us they would be continuing to recruit new staff members, and also reviewing staffing levels to determine whether or not they were sufficient to meet people's needs.

The deputy manager explained to us that there were a series of checks which were carried out to ensure that members of staff were of suitable character to work at the service. They explained that, before they could start at the service, references of previous employment were sought, as well as Disclosure and Barring Service (DBS) criminal record checks. We checked staff recruitment files and saw evidence that references and DBS checks had been obtained, along with full employment histories, to ensure that staff members were safe to work at the service.

People felt that they were safe at the service, and well looked after. One person said, "I feel safe." Another told us, "I do feel safe here, I am quite happy." People explained to us that they felt staff worked to keep them safe from harm or abuse. People's relatives shared this point of view; however they told us that they had some concerns about people's safety due to the problems around staffing levels at the service. During our inspection we saw that people appeared relaxed and confident in the presence of members of staff.

People told us that they received their medication from staff members on time and in accordance with the prescriber's instructions. We observed staff giving people their medication. They did so patiently and were prepared to give people time and explain what they were taking if they needed it. They also ensured people had a chosen drink to hand, and stayed with the person until they had taken their medication. We spoke to a nurse about medication. They explained that they gave people their medicine in accordance with their prescription and used a Medication Administration Record (MAR) chart to guide them, and to record when

medicine was given. We checked people's MAR charts and saw that these were completed appropriately, with signatures used to indicate that medication had been given. If medication had been refused, or 'as required' (PRN) medication had been given, appropriate symbols and the reverse of the MAR charts had been used to record this. We also saw that there were suitable systems in place for the ordering, checking in and storage of medication, and that stock levels matched the records.

Requires Improvement

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff told us that they were aware of the act, and the principles behind it, however they were not involved in applying it regularly. People's records demonstrated that there was a lack of consistent application of the MCA, which meant that decisions were not necessarily being made in people's best interests. For example, we saw that in one person had a 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) order in their care plan. This stated that this had not been discussed with the person, as they lacked mental capacity and there was a note stating that it should be discussed with the person's family. There was no record of how the person's mental capacity had been assessed, or of any discussion with the person's family. In other files we saw that consent forms for care were in place, but were not signed at all, or had been signed by a member of staff, instead of the person receiving the care. In these cases, there were no mental capacity assessments, to demonstrate that the person had been unable to make the decision for themselves, or evidence that a best interests process had been followed, when making a decision on people's behalf. In some people's care plans, we did find evidence that MCA assessments had been carried out, along with evidence that a best interests process had been followed. This showed that the principles of the MCA had been applied in some cases when people were unable to make their own decisions, but not all.

We found evidence that DoLS applications had been made for a number of people, however this was in a file in the manager's office, and was not always recorded in people's individual care plans. In addition, it was unclear what stage each DoLS application was at. The tracking tool which had been put in place did not record when DoLS were granted or expired, and had not been completed for each application which had been made.

The principles of the Mental Capacity Act 2005 had not been routinely applied when making decisions on people's behalf, due to a lack of capacity. This was a breach of regulation 11 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we observed members of staff providing people with different choices, and seeking their consent before providing them with care. We saw that staff members spoke to people about what they wanted to eat or drink, or where they wanted to spend their time. They gave people time to make their decision and took notice of the answer they received. They also ensured they sought people's permission before helping them to move or provide them with care or support.

Staff members told us that they did not receive regular supervision sessions at the service. They told us that these did take place, but that they were irregular and that they did not find them to be a useful exercise. One staff member said, "I have had some supervisions, it is basically as and when and not useful." Staff members also told us that they did not have regular access to the manager, and therefore could not share any concerns they had about the care being delivered. We checked staff records and found that supervisions had not been carried out regularly. Some staff members had only received one supervision in the past year, others had memos or references to staff meetings recorded as a supervision session. This meant that staff were not always supported in their roles, and their performance was not always monitored to identify areas for development.

People told us that they felt the staff employed by the service had the skills and knowledge required to meet their needs. They told us that the staff received regular training, however did not feel that the agency staff used by the service were as well trained. They also felt that changing faces in the staff team had an impact, as new staff members did not always have the same knowledge and experience as previous staff members. One person told us, "The regular staff are trained well, but i don't feel the agency staff are well trained." Another person told us, "Only problem is staff keep changing, I don't know about their training." People's relatives also expressed concern about the impact of staff turnover and reliance of agency staff, particularly with regard to skills and training. One relative said, "Training and knowledge is an issue. Why is there such a high turnover of staff?" Another relative told us, "Training and them knowing my Dad's needs are a big problem, all the staff are leaving."

Staff members told us that they had received regular training courses to help give them the skills and knowledge that they required to perform their roles. They explained that when they started at the service they completed an induction process which included shadowing experienced staff and completing mandatory courses such as safeguarding and moving and handling. In addition, they received regular and on-going training courses to develop and maintain their skills. One staff member told us, "We get lots of training; we do it very often to refresh everything." We checked staff training records and found that staff had received training on a regular basis to help maintain their skills.

We also spoke to the peripatetic manager about training. They informed us that they planned to carry out a full review of people's needs and identify the training that staff would need going forward. They explained that they planned to use an external training provider to deliver specific courses 'in-house', and we found that they had met with them during the second day of our inspection help identify the courses that would be required.

People told us that they were generally happy with the food at the service, however at times the quality of it was variable. One person said, "Sometimes the food is good." The food is improving now." Relatives also felt that there were times when the food was not always good, particularly regarding people's specific dietary requirements. One relative told us, "Mum needs a soft diet and she does not get it." During the inspection we saw that food was served to people in their chosen room, and that dining rooms were well presented to help people feel comfortable eating their meals there if they wished.

Snacks and drinks were also available throughout the service. We spoke with the deputy manager about food at the service. They explained that the chef had left the service, which had caused disruption to food ordering and preparation. The peripatetic manager informed us that a new chef had been recruited, along with additional cooks and kitchen assistant. They had also reviewed food ordering systems at the service, to ensure fresh food was available, and that people's specific dietary requirements could be met. The new chef told us that improvements had already been made and they were aware of people's specific needs. There were also plans in place to meet with people to discuss their wishes and to design a new menu which incorporated the meals that people wanted to eat. Records showed that people's specific needs were available, so that catering and kitchen staff were aware of the different types of food and drink that people needed.

People's health needs were being met by the service. People told us that, if necessary, staff would arrange appointments with healthcare professionals for them, both in the local community and within the service. One person said, "They will get the doctor if we ask." Another person told us, "I do see the doctor." Members of staff told us that they reported any health concerns to senior staff, who made sure that people saw the healthcare professionals that they needed to. Records confirmed that people were seen by their GP at the service, and that specialist appointments were made when required.

Requires Improvement

Our findings

People felt that staff at the service treated them with kindness and compassion, however felt that there were not enough regular staff to build positive relationships and get to know them properly. One person told us, "Not a lot of continuity of care goes on. When it's personal care you like to know your carers but they come and go here." Another person said, "Basically they are all okay. We have a laugh and a joke but the main problem is they keep leaving and we have stand-in staff, who I don't know." People went on to explain that there were often different members of agency staff at the service, which meant that these staff members did not have an understanding of their needs and wishes, so they had to regularly explain how they would like their care. People's relatives also felt that the regular changes to the staffing at the service prevented their family members from developing a strong relationship with them. One relative told us, "Turnover of staff is quite ridiculous." Another said, "I am not sure that the changing staff know enough about the residents."

Staff members told us that they tried to build strong relationships with people living at the service, however changes to the staff team, and the use of agency staff, made it difficult for people to get to know the staff caring for them. One staff member told us, "We use agency very often, we don't always get the same [agency staff member], this is horrible, people don't see familiar faces." Staff members also commented that, due to regularly being short-staffed, they were unable to spend time sitting with people socially, or engaging them in conversation, instead, the care they provided was based on the tasks that had to be completed.

Our observations during the inspection supported this view. We saw that staff were moving from task to task, unable to stop and spend time engaging and socialising with the people they were caring for. We spoke with the peripatetic manager about this. They agreed with these observations and informed us that they planned to recruit additional staff, to help maintain a constant workforce. In addition, they would review staffing levels to identify areas where they may be changed to allow staff to spend more time with people and providing them with social interaction.

Care plans had been produced for each person at the service; however they had not been routinely involved in writing these plans. None of the people we spoke to were able to tell us how they had been involved in planning their care, or were aware that there was a care plan in place to guide staff regarding the care that people needed. We looked at people's care plans and found that these did not show that people, or their families, had been involved in planning their care. There was nothing to show that people's views about care plans had been sought to ensure they were reflective of their needs and wishes. This meant that the service was unable to demonstrate that the content of people's care plan was a true reflection of the care and

support that they wanted or needed.

People were not always provided with information about the service, or involved in making decisions regarding developments at the service. People told us that they were not aware of meetings held at the service for themselves or for their family members, to help share information and seek people's views and opinions. We checked records of meetings, and found that there was only one recorded, which had been held recently to inform people and their family members about the service going into administration.

People told us that they were treated with respect and dignity by members of staff. One person said, "They are all kind and patient." Another said, "Yes they are lovely." People explained that staff members always spoke to them politely and respectfully, and treated them in a dignified manner. They said that when staff were providing personal care they always made sure people were covered and that doors and curtains were shut to help preserve their privacy. Throughout our inspection our observations confirmed that people's privacy and dignity were maintained. For example, we observed staff discreetly re-arranging people's clothing to help make sure they were covered and comfortable.

Requires Improvement

Our findings

People's care was not person-centred. People and their family members explained to us that their specific needs and wishes were not always represented by the service, or by the care plans which staff used to guide them. One relative told us, "They don't seem to have the time to care for the residents properly, nor know his likes or dislikes about his care." Members of staff also expressed concerns about the care that they were able to provide, particularly when staffing levels were low. One staff member told us, "It's task orientated, not person-centred."

People also told us that they had not been involved in planning or reviewing their care plans. Many of the people we spoke with were not aware of what their care plan was, or of how staff should use it to provide them with the care that they required. In addition, some of the people we spoke with who were aware of their care plans did not feel that staff used them to help inform their care delivery. One person told us, "My daughter is a nurse so she hassles them about that, but it is poor really. I am not sure that they really use what is written down." People's relatives also felt that they were not always involved, and that the service did not provide them with the information they needed all the time. One relative said, "It is quite difficult to get information from the management or nurses."

People had care plans in place; however these were not fit for purpose and did not support staff to provide people with person-centred care. Members of staff told us that the care plans were very long and were difficult to use to get the information they needed. One staff member said, "The care plans are horrendous, they are like war and peace." Another staff member told us, "The care plans are very repetitive and difficult to use." We checked people's care plans and found that they were extensive and often repeated themselves, for example, we found that there were three different forms of nutritional assessment in place. This meant that staff were not always sure of which one to use, and they were therefore not all completed on a regular basis.

We also found that, whilst care plans recorded people's needs, they did not always demonstrate that people's individual wishes and interests had been taken into account. For example, in the box for one person's interests, it was recorded; 'I don't like to do many activities.' There was nothing to show staff what activities this person did enjoy, or what had been done to attempt to find out how they liked to relax and unwind.

The deputy manager told us that care plans were reviewed on a regular basis; however these reviews did not always involve people, or their family members. Care plans showed that there were regular reviews of

people's care plans, however they did not show that people had been consulted, or that their family members had been invited to contribute to the review process. This meant that care plans were not always reflective of people's current needs and wishes and therefore failed to provide staff with the information they needed to ensure that people's preferences were being met by the service.

Daily notes were inconsistently completed, and failed to provide a full picture of what people had done each day, and how they had been throughout the day. For example, we saw in one series of daily notes, staff had changed between the person's given name and their preferred name. This provided a confusing picture regarding the care that this person actually received, which was compounded when another name was used to record this person's care, which did not feature in the person's care plan at all.

Information in care plans and daily notes was often difficult to follow and double check. Care plans, daily notes and monitoring charts were stored separately from each other, which resulted in further repetition and increased the chances that staff may miss important information. We spoke to the peripatetic manager about the care plans at the service. They informed us that they felt the care plans were too large and were not person-centred. They intended to carry out a full review of each person's care, and planned to implement more streamlined care plans which contained more person-centred information.

People's care and treatment was not always planned in such a way as to ensure that their preferences and needs were met by the service. People and their family members were not involved in making decisions about their care. This was a breach of regulation 9 (1) (3) (a) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there were occasional activities and entertainment arranged by the service. They told us that these were group activities and if they wanted to take part they could. During the first day of our inspection a singer came in to provide entertainment on the ground floor of the service. We also saw that there were a number of games and activities spread throughout the building in communal lounges and dining rooms, however these were not being used regularly, as staff did not have the time to sit and with people and take part in a game or similar activity. We checked people's care plans and could not find evidence to show that their views and wishes regarding activities had been considered and used to help plan appropriate entertainment for people. The peripatetic manager told us that they planned to review activities on offer and encourage staff to make use of the equipment within the building more frequently.

People and their families gave mixed feedback about the complaints process at the service. Some people told us that they were aware of how to make complaints and had been happy with how they had been handled, however some other people were unsure about how to raise a complaint about the care that they received. One person told us, "I have not complained to anyone, not sure who I would tell." A relative told us, "I have complained about that in the past. It does seem better now." Records showed that one written complaint had been received by the service; there was no log of verbal feedback or complaints that had been received, or of action taken as a result of that feedback. The written complaint had been responded to in writing; however there was no evidence to show that an investigation had taken place to determine the facts and ensure that appropriate action had been taken. In addition, the remedial action which had been suggested in the response had not been implemented by the service. This meant that the complaints and feedback systems at the service were not effective in helping the provider to identify areas for improvement, or to develop the service. There was no evidence that lessons had been learned as a result of people's feedback.

Inadequate

Our findings

There was a lack of oversight and quality monitoring systems in place at the service. People and their family members told us that they were not asked about the care that they received and were not aware of any meetings held at the service to help share information or to gain their feedback about the quality of care that was provided at the service. We spoke with members of staff about this, and they confirmed that there were not regular meetings, or surveys carried out to get some insight from people and their family members. We checked records and could not find any evidence to show that the provider had organised meetings for people and their family members, or used satisfaction surveys to collect feedback from people and use this as a tool for developing the service.

The provider had failed to ensure that there were sufficient numbers of regular staff working at the service to provide people with continuous care from staff members who were familiar to them. They had failed to identify the need for additional staff and to recruit accordingly, which meant that the service had to rely on agency staff and was often short staffed. This meant that people's needs were not always met by the service.

Staff members did not receive regular supervision, therefore development plans to help staff improve their performance were not identified. In addition, concerns or areas of poor performance were not examined and managed appropriately. This lack of oversight of staff meant that areas where staff were not performing well may not be identified and dealt appropriately.

Care plans had not been reviewed appropriately, to ensure staff had all the information they needed in a user-friendly and understandable format. The provider had not taken steps to discuss the format of care plans with staff or to consider how they could improve them. In addition, the provider had failed to ensure that people and their relatives were involved in producing care plans; therefore they had not ensured that people received person-centred care, which was sensitive to their specific needs and wishes. When people were unable to consent to their care, or make decisions for themselves; there was inconsistent use of the Mental Capacity Act 2005 and the provider had not taken action to ensure that decisions were made in people's best interests. This meant that the provider had failed to ensure that people received person-centred care, or to act in the best interests of people who lacked mental capacity.

Risks to people's health and safety had not been identified by the systems and checks at the service. General risks concerning the service and the environment had not been managed effectively. For example, during our inspection we observed that an emergency exit push-bar had been broken off from the exit door. This meant that in the event of an emergency, such as a fire, this door could not be opened. None of the staff or

management we spoke with was able to tell us when this had happened, or what plans were in place to resolve the problem. This placed people at potential risk as the environment was not suitable to keep them safe. We raised this with the deputy manager and previous manager during the inspection, and they made arrangements for the door to be fixed that day.

We looked at maintenance records and saw that there were not regularly conducted checks around the service, to ensure that problems such as the emergency exit were identified and acted upon quickly. The deputy manager explained to us that the maintenance operative had left the organisation in January 2016, and that checks had not been completed since they left. Records confirmed that this was the case. We spoke with the peripatetic manager about this issue, and they informed us that the maintenance operative planned to return to the service. During the second day of the inspection we met with them and they explained that they were working with the new management team to ensure that the environment was safe and that regular maintenance checks would take place going forward.

There were not effective systems and processes in place to ensure that the service was running smoothly, and that areas which required attention or improvement were attended to. Staff members told us that they were not aware of quality assurance procedures being carried out. One staff member said, "Previously the manager was not doing quality assurance or checking care plans." We spoke with the deputy manager, who was not aware of the systems which had been in place at the service, to monitor the quality of care which was being delivered at the service. The peripatetic manager also confirmed that they had not identified any regular quality assurance processes at the service, since the administration company had been involved.

We also spoke to the peripatetic manager about equipment servicing. They told us that as part of their immediate action plan for the service, they would arrange for checks of all moving and handling equipment, such as hoists and slings, as well as electrical safety checks of portable electronic appliances. They also told us that they would have a full fire risk assessment carried out, and would act on any recommendations from this.

We checked records for the service and found evidence that equipment, such as hoists, fire extinguishers and alarms, had been tested regularly, however they had not been tested recently. For example, we saw that all the hoists and slings in the service were due to be tested in December 2015; however we could not find any evidence that these checks had taken place. We spoke with the peripatetic manager and deputy manager about this, and they were unable to find records to demonstrate that these tests had been completed. This meant that equipment at the service had not been checked recently to ensure that it was fit for purpose and ready to be used safely. The provider had failed to ensure that there were systems in place to regularly service this equipment, which resulted in increased risks to people's safety.

We looked at records in the previous manager's office and found that some quality assurance processes had been completed, however these had not been conducted regularly, and they had failed to identify problem areas at the service. For example, care plan audits had only been completed for 14 people, and these failed to identify problem areas or set out an action plan to demonstrate how improvements had been made. No care plan audits had been completed since November 2015. In addition, a monthly hoist audit had not been completed since July 2015 and a weekly manager's report had only been recorded once in 2016. This demonstrated that there was a lack of managerial oversight at the service, to ensure that care was being delivered to a high standard and to identify areas in which the service needed to improve.

There was not a registered manager at the service. There had been a number of changes of management in the past year at the service, which had prevented a long-term manager from registering with the Care Quality Commission (CQC). We spoke with the peripatetic manager about this, and they informed us that a

new manager had been interviewed and offered the position of manager at the service. They told us that this person was currently negotiating their notice period at their previous role and assured us that they would register when they started working at the service. We saw records to confirm that this recruitment had taken place, along with the recruitment of a number of new staff members, such as carers and kitchen staff.

The provider had failed to ensure that there were systems in place to monitor incidents and accidents at the service, and ensure that they were reported to the appropriate external organisation. As a result of this, they had failed to inform CQC of potential safeguarding issues, as part of their statutory obligations.

Systems or processes had not been established and operated effectively to ensure that the quality and safety of the service was assessed, monitored and improved. This was a breach of regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The peripatetic manager told us that there were a number of audit tools and checks which they planned to implement, to help identify and prioritise the areas of the service that required improvement. They also explained that the care management company had a full audit tool which they used when they first became involved in managing the service. We looked at this tool and saw that it had been used to build a comprehensive picture of the service and the areas in which improvements were needed. Action plans had been drawn up as a result of identifying these areas, to help ensure improvements were made in a timely manner.

There was not a positive culture or atmosphere amongst the staff at the service. Staff members explained to us that they did not feel that they had been well supported by previous management and were concerned about problems at the service, including staffing levels and the service being in administration. One staff member said, "There is no leadership, there isn't the support. If we had the right support and the right staff, we'd be okay." Another staff member said, "We don't know what is going on, we are really concerned." A third member of staff told us, "They just need to sort out the management. It's stressful; you worry about your job." Staff members went on to tell us that they did not feel supported or valued by the management of the service or the provider, and that they were not empowered to perform their roles to the best of their abilities.

We spoke to the peripatetic manager about this. They agreed with the comments that staff had made, as they had identified these problems themselves when they assessed the service. They informed us that they were committed to working with staff to make improvements to the service and help them to feel more secure in their roles and involved in the running of the service. The peripatetic manager and other senior staff from the care management company had only started at the service after the first day of our inspection. On the second day we observed that they had made some positive changes at the service to improve the atmosphere at the service. This included moving the manager's office to a more visible area of the service and spending time talking to staff members about the service and areas which needed to be improved. Staff members appeared calmer during the second day of the inspection, and expressed optimism about the future of the service under the guidance of the new management team.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not always planned in such a way as to ensure that their preferences and needs were met by the service. People and their family members were not involved in making decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act 2005 had not been routinely applied when making decisions on people's behalf, due to a lack of capacity

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to ensure that people were protected from potential abuse.

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

Systems or processes had not been established and operated effectively to ensure that the quality and safety of the service was assessed, monitored and improved.