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Threen House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 09 and 10 August 2017. The visit on 09 August was unannounced and we told the provider we would return on 10 August to complete the inspection.

The last comprehensive inspection of the service was in February 2017. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not operate effective systems to investigate possible abuse; the provider did not always manage people's medicines safely; staff did not have the training and supervision they needed to provide safe and appropriate care for people; the provider did not arrange appropriate activities that met people's needs and preferences and audits and checks carried out by the provider did not identify improvements that were needed to the quality of care provided. We also found one breach of the Care Quality Commission (Registration) Regulations 2009 as the provider did not inform the CQC of possible safeguarding incidents.
Following the inspection we issued the provider with three Warning Notices and gave them two months to comply with the Regulations. There is a condition in place, agreed with the provider that they must not admit new people to the service, without the written agreement of the Care Quality Commission.

In May 2017 we carried out a focused inspection to review actions the provider had taken in response to the Warning Notices and also discussed information of concern we received from the registered manager regarding staff recruitment. We found the provider and the registered manager had made some progress towards meeting the requirements of the Warning Notices, although further work was needed.

Threen House is a registered care home for older people who require nursing or personal care, some of whom are living with the experience of dementia. The service can accommodate up to 26 older people, in single or shared rooms. At the time of this inspection, 12 people were using the service.

The service did not have a registered manager at the time of this inspection. 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.

The provider is registered with the Care Quality Commission (CQC) as an individual and has a condition of registration to have a registered manager. The provider appointed a manager in August 2016 and they were registered by CQC on 07 May 2017. The manager left the service later in May 2017 and another manager appointed by the provider in June 2017 resigned after three weeks in post. The provider informed CQC they had appointed another manager who was due to start work in the service at the end of August 2017.

The provider did not comply with regulations when carrying out regulated activities and had not taken action to address all of the concerns raised in previous inspection reports.

The provider did not carry out checks on staff they employed to make sure they were suitable to work with people using the service. This may have placed people at risk of unsafe or inappropriate care.

Health and safety checks the provider carried out did not always identify possible risks to people using the service.

Staff did not receive the training they needed to care for and support people using the service and the provider did not always deploy staff in a way that ensured the safety of people using the service.

Some parts of the premises were in need of redecoration or refurbishment.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We are taking enforcement action against the provider for failing to meet regulations. Full information about CQC's regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. It has been in special measures since July 2015. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Some aspects of the service were not safe.

The provider did not carry out checks on staff they employed to make sure they were suitable to work with people using the service.

Health and safety checks did not always identify possible risks to people using the service.

The provider did not always deploy staff in a way that ensured the safety of people using the service.

People received the medicines they needed safely.

The provider notified the local authority and the Care Quality Commission about possible safeguarding incidents.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff did not receive the training they needed to care for and support people using the service.

The provider had improved the supervision of staff and the manager had completed annual appraisals where required.

People told us they enjoyed the food provided in the service.

Some parts of the premises were in need of redecoration or refurbishment.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Staff did not always treat people using the service with respect.

The provider did not always demonstrate respect for people's dignity and privacy.

People using the service told us they were well treated and they liked the staff who cared for them.

Is the service responsive?

Good

The service was responsive.

The provider had improved the recording of activities people took part in and there was evidence people had access to a range of appropriate activities.

People's care plans included their health and social care needs and staff reviewed these monthly.

The provider responded to complaints in line with their policy and procedures.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not taken action to meet requirements and warning notices we issued following previous inspections.

The service did not have a registered manager. Three managers the provider appointed had left the service in the previous 12 months.

Audits and checks the provider carried out did not identify areas that needed improvement.

Threen House Nursing 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 took place on 09 and 10 August 2017. The visit on 09 August was unannounced and we told the provider we would return on 10 August to complete the inspection. The inspection team on 09 August comprised two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection was a family carer of a person living with the experience of dementia. Two inspectors returned to the service on 10 August to complete the inspection.

Before the inspection we reviewed the information we held about the provider and the location. This included previous inspection reports, action plans the provider sent to us following these inspections and statutory notifications the provider sent us about significant events that affected people using the service.

During the inspection we spoke with the provider, seven people using the service, three relatives, one nurse and three care staff. We also looked at a number of records, including accident and incident reports, medication records for six people, four people's care records, 16 staff recruitment and training records, audits and checks the provider carried out to monitor quality in the service and make improvements.

Inadequate

Is the service safe?

Our findings

People may have been at risk of unsafe or inappropriate care because the provider did not carry out pre-employment checks on new staff before they started to work in the service. One of the staff records we reviewed showed the member of staff had left their previous employment at a nursing home for 'personal reasons'. The record of the person's interview did not include a discussion of the reason the person left their previous job or a reference from the nursing home as their last employer. This member of staff was also working without a full Disclosure and Barring Service (DBS) criminal records check. The provider told us they asked staff to bring in their DBS check when they received it but they were unable to show us evidence that they had seen and checked these.

A second member of staff also did not have a full DBS check and one of their references was provided by a colleague rather than their line manager. The provider was unable to explain why they had not discussed this with the member of staff when they recruited them. The provider also did not have evidence of this person's right to remain and work in the United Kingdom. The member of staff did have a student visa that allowed them to work for 20 hours each week in term time but they told us they had completed their studies. There was no evidence the provider had checked the person's status and their eligibility to continue working.

The recruitment records for a third member of staff included a reference from a domiciliary care agency the person had not listed in their employment history. The employment history showed they had also worked in a nursing home from February 2014 to December 2016 but they had not given this employer as a referee. There was no evidence the provider had checked why the care worker had given the agency as a referee or attempted to obtain a reference from the nursing home they had worked in previously.

During the inspection the provider told us that care staff who did not have a full DBS check would only work with another member of staff who had been fully checked and would not work alone with people using the service. However, the two care staff on duty during the inspection did not have a full DBS check and they told us they worked together to care for and support people. This meant staff who had not been fully checked were working without the supervision that was required to make sure they worked safely.

These failures to carry out checks on staff before they started work and fully investigate their employment history meant the provider could not be sure all of the staff they employed were suitable to work with people using the service.

The staff rotas we checked showed that there was a qualified nurse on duty at all times of the day and night, supported by a team of care assistants, catering and domestic staff. The provider also offered placements to two volunteers who worked in the service for two and three days each. While the number of staff on duty was sufficient to meet the care and support needs of people using the service, the provider did not always deploy staff in ways that would ensure the safety of people using the service. For example, the rota for August 2017 showed that one care assistant was working 17 days without a day off and care staff who had not completed a full Disclosure and Barring Service criminal records check were working without

supervision.

In July 2017, we shared evidence with the provider that a nurse they employed was also working in another care home. The staff rotas for the two services showed the nurse was working a 12-hour day shift in one service, followed immediately by a 12-hour waking night shift in the second service. This placed people using the services at risk of unsafe care as the nurse was responsible for managing people's medicines and supervising care staff as they were the person in charge of the service during their shift. When we shared this information, the provider told us the nurse had not declared their other employment, in line with the provider's 'moonlighting' policy. They also said they would make sure the nurse no longer worked in the service. However, when we arrived for this unannounced inspection, the nurse was on duty and the rota showed she worked in the service for four days each week. We discussed this with the provider who told us the nurse had resigned from their permanent position but continued to work as a bank member of staff. Following our inspection, the provider told us they had discussed their 'moonlighting' policy with the nurse but had taken no other disciplinary actions.

These were breaches of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had some systems in place to carry out checks on the safety of the premises but these were not always effective. We saw that the provider carried out and recorded daily checks of people's bedrooms and weekly health and safety checks that included water temperatures, window restrictors, fire alarms and emergency exit routes. However, the checks the provider had completed in the week of our inspection did not identify a number of potential hazards. For example, in one bathroom we found a broken light fitting, the aid call alarm cord was broken and could not be reached by a person if they fell to the floor, a bin with a handwritten 'clinical waste' sign was not fit for purpose as it was a domestic swing-top household bin and an aerosol of air freshener was kept next to the wash hand basin. This presented risks to people using the service, in particular those people who were living with the experience of dementia.

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

People told us they liked living in the service and they felt safe. Their comments included, "Not like being at home", "Yes [I like living here]", "It is alright, but I'd rather have my own home", "Yes I do [feel safe]" and "I do feel safe, I feel comfortable here".

The provider had systems in place to care for and support people safely. Information we held about the service showed the provider notified the Care Quality Commission (CQC) and the local authority of possible safeguarding concerns. When we asked staff to tell us what they understood by 'safeguarding', they told us, "Maintain residents' health and safety, avoid injury and accident and protect them safely" and "Making sure of the person's welfare and no abuse from family or staff member. Recording everything and protecting the person".

Staff training records showed nurses and care staff had completed safeguarding training in November 2015 or January 2016. We did not see evidence that refresher training had been provided.

People using the service received the medicines they needed safely. We saw that an audit by the Clinical Commissioning Group's pharmacist in May 2017 concluded, "Overall the medicines management within the home has been well run." We saw the provider had protocols in place for the covert administration of medicines and PRN ('as required') medicines they had agreed with the GP. Staff completed Medication

Administration Record (MAR) sheets accurately and we saw no errors or omissions.

The provider completed assessments of possible risks to people using the service and staff had guidance on how to mitigate the identified risks. We saw risk assessments that covered skin care, falls, fire safety and nutrition. The previous registered manager had reviewed the assessments we saw at least monthly and the assessments included risk management plans for nurses and care staff to follow. Where they identified possible risks to people using the service we saw the provider had liaised appropriately with health care services. For example, we saw referrals to people's GPs for general health care issues and to other clinicians, including the tissue viability nursing service and speech and language therapists, where specific risks were identified.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection of the service in February 2017 we found that staff working in the service did not receive appropriate support, training, supervision or appraisals to enable them to carry out the duties they were employed to perform. At the inspection in August 2017 we reviewed the provider's training records and saw that some nurses and care staff had completed training in 2017 although significant gaps remained in the evidence the provider gave us. For example, the provider's training matrix showed one nurse had completed no training in 2017, a second nurse had only completed a first aid course and an introduction to dementia and a third nurse's name was not included on the training matrix. The matrix also showed no nurses or care staff had completed infection control and safe food handling training in 2016 or 2017.

The provider's training system required staff to watch a DVD recording from the Aged Care Channel (ACC) and complete a workbook based on the programme to assess their understanding. The service's registered manager would then review the workbooks in supervision and assess the member of staff's competency. We did not see any completed workbooks or record of competency assessments by the registered manager and we could not guarantee that staff had completed the training they needed to care for and support people using the service.

The Care Certificate is a set of standards for social care and health workers. It is the minimum standard that should be covered as part of induction training of new care workers. New care workers should complete this training within six months of starting work. The provider's training matrix showed that four care staff were "In progress and registered" for the Care Certificate in 2016 but there was no evidence they had completed their training on the 2017 training record.

This was a further breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we asked staff about the training they had completed, their comments included, "I have done moving and handling, food hygiene, fire safety, safeguarding and medication training", "For fire safety training [the provider] walked round the building and pointed out the fire extinguishers and other equipment", "I filled in workbooks for the training and [the provider] marked them and gave them back to me. You get certificates", "I have done first aid, dysphagia, diabetes, aging. The training was in house and used a DVD and booklet. [The provider] checks the booklets for the training and marks them and gives them back. The pharmacy did the medicines training with a discussion and question booklet. You get certificates for the training", "We spoke about safeguarding, moving and handling, pressure sores with the manager. I also spoke with [the provider] but I have experience so have done it all before. The manager demonstrated and talked through topics and then questioned me. It was not DVD based training", "I had three or four days' induction which was relaxed and not stressful" and "I did moving and handling training on Wednesday. It was very good as they told us the names of the parts of the spine as part of the training".

On the first day of the inspection we saw that some staff completed moving and handling training that used

equipment provided in the service.

When we asked staff if they had support and supervision with a senior member of staff they told us, "I have supervision twice a month and there are notes from the meetings. [The provider] is always here if I have a question. I find the supervision sessions very helpful", "I had supervision with the previous manager every three months. It was very helpful. It helps you work out how to improve yourself and discuss it with your manager", "[The provider] is around all the time. Every day he sits next to me when I am doing the log book and checks to make sure I am doing the job properly. The nurses also observed me working", "We have monthly team meetings where we discuss the residents and their care", "The team meetings mean we can talk about all the residents and discuss if their needs have changed and if we need to do things differently" and "[The provider] is very supportive; we can disclose anything to him. We can discuss anything with him. The nurses are very helpful".

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We found that, although there were some restrictions placed on people for their safety, people were not deprived of their liberty unlawfully. The previous registered manager had applied to the local authority for authorisation when they needed to and authorisations were in place when necessary. Where one person's relatives held Lasting Power of Attorney (LPA) for health and welfare issues, we saw the provider had a copy of the LPA on the person's care records.

Staff told us they had received training on the Mental Capacity Act 2005 and the provider's training records showed 11 nurses and care staff had completed this training in November 2015. The provider had not completed this training although they told us they worked in the service as a health care assistant. When we asked staff what they understood about what the MCA means when providing care, they told us, "I did training before I came to work here. Their care needs are explained and most people here have capacity. Let them say what they want when they are angry" and "I did the training a while ago – capacity to make specific decisions. Assume the person has capacity until assessment of needs".

People told us they enjoyed the food provided in the service. Their comments included, "The food is very good and always well cooked", "When you are at home on your own, this is a God send, good food and nice friendship", "The food is pretty good, not marvellous like a restaurant, but if I had a complaint about the food they would do something about it" and "I don't usually bother, but they come and offer tea and coffee". We saw that two people had their lunch in the conservatory. They both had chicken with a roast potato, mashed potato, carrots and greens. Staff attended to each of them and asked them if they wanted their food cut up and they did, so staff did that for them. The food looked of a good quality and well cooked. Most people sat in armchairs in the main lounge to eat on tables. Staff supported two people to eat as they were unable to feed themselves. This was done carefully and with patience and staff made sure they finished their meals.

The provider confirmed there was a choice of main course at lunchtime and the cook explained that they would provide an alternative if a person did not want the day's planned menu.

People's care records included information about their health care needs and how staff in the service met these. Where people had a Do Not Attempt Resuscitation (DNAR) form in their records we saw the provider had discussed this with the GP and the person's relatives or representatives. Care records included details of people's medical appointments and we saw evidence of joint work with hospital clinics, the tissue viability and district nursing services and the intermediate care team.

The premises were a converted residential property with communal spaces, bedrooms and the kitchen on the ground floor and more bedrooms, bathrooms, toilets and laundry in the basement and bedrooms on the first, second and third floors. The service had a large, attractive garden and a summer house that is mainly used by staff. During the inspection we saw most parts of the service were clean and tidy, although some communal areas and bathrooms were used for storage of wheelchairs, hoists and other equipment which meant access for people using the service was restricted. Some carpets were in need of replacement, especially in the main lounge on the ground floor. We saw the provider had an annual development and maintenance plan for 2017 that showed they planned to complete extensive redecoration works by the end of October 2017. This included the redecoration of 14 bedrooms, bathrooms, corridors and communal areas and would greatly improve the physical environment for people using the service.

Requires Improvement

Is the service caring?

Our findings

At previous inspections we have discussed the use of cameras with the provider. Two people using the service spent most of their time in their bedrooms and the provider had installed cameras to enable staff to monitor them. During this inspection, the monitors were located on top of the medicines trolley, in the main lounge where nurses and care staff worked at a table to complete paperwork. However, other people using the service and visitors could see the monitors and also hear what was happening in each person's room. This did not demonstrate respect for people's privacy or dignity. When we discussed this with the provider, they told us the cameras were in the people's best interests and they showed us the issue had been discussed and agreed by a multi-disciplinary team in one case and as part of a Deprivation of Liberty Safeguards (DoLS) assessment for the second person. However, the location of the monitors in a public area did not demonstrate respect for people's dignity and privacy.

While we saw some caring interactions between the provider, nurses and care staff and people using the service, this was not always the case. For example, we saw one occasion when a volunteer was standing next to a person in a wheelchair. When we asked the volunteer about their role they said they helped with feeding people. The volunteer then picked up the beaker and placed it very quickly to the lips of the lady and tipped it right the way up so it was resting on the bridge of the person's nose. She did this a second time to drain any remaining fluid. When we asked the volunteer if she had any training on how to feed people they told us they did things how they wanted. The person had a 'bib' on which was wet and had food on it and there was a layer of tissue around the person's neck which was wet. The volunteer said they put the tissue there as food and drink was spilt quite often. We reviewed the provider's training records and the volunteers name was not included to show they had completed training relevant to their role.

On another occasion, we saw that a person asked the home's administrator if someone could take them to the toilet and he said he would find someone. A few minutes later no one had arrived with a hoist to take the person to the toilet so we asked them if they wanted us to find someone. They told us, "Its ok I usually just [wet] myself sitting in the chair as it can take so long". We told the provider that the person needed to use the toilet and they replied, "That's because you are not paying enough attention to them and they do it all the time." The provider then said loudly to the person from the other end of the conservatory, "If you don't think about wanting to go you won't need to". The person waited for approximately 15 minutes before care workers arrived with the hoist and supported them to the bathroom.

These were breaches of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they were well treated and they liked the staff who cared for them. Their comments included, "[We are treated] very well", "It's not too bad. The staff are okay", "Sometimes they are a bit busy but I don't think you will find a better care home", "Oh yes, [the staff are] very good, very caring", "The staff do change every now and again, they do move on but we had a visit today from a staff member who left to have a baby", "[The staff are] brilliant, very good and very helpful", "I like living here, the staff are very good, cannot grumble at them at all", "Yes, the staff are very caring", "One girl needs to be reminded of

what to do but other than that, yes, they are very good" and "No complaints at all, If I am not feeling well they watch over me", "[The staff are] only human they have their moments, but they are alright" and "Oh yes, they are very good, just like friends, not overpowering, nice and comfortable".

A relative also commented, "Yes, definitely, I have a good relationship with the staff. They are very good".

We saw evidence that the previous registered manager had reviewed people's care plans monthly but we did not see evidence in all of the care plans we checked that people or their relatives were involved in planning or directing their care. Three of the care plans we saw included a "This Is Me" booklet that relatives had completed and signed on behalf of their family member. These included useful information about significant people, events and places in people's life histories, as well as their likes, dislikes and preferred routines.

During the inspection we did see some positive and caring interactions between nurses and care staff and people using the service. For example, we saw two care staff used a standing hoist to transfer one person from their armchair to a wheelchair on a number of occasions. They did this patiently, they made sure they explained to the person what was happening at each stage of the transfer and reassured them when they became anxious. We also saw one of the care staff painted a person's nails in the lounge. They sat with them and chatted while they did this and we saw the person obviously enjoyed the attention.

Good

Is the service responsive?

Our findings

At our last comprehensive inspection of the service in February 2017 we found that the provider did not have a programme of daily planned activities and people's care records included very few mentions of any activities taking place. For long periods of the day, people sat in the lounge or conservatory with little stimulation. At the inspection in August 2017 we found the provider had improved the recording of activities and this reflected the opportunities that were available for people. Staff recorded in people's care records the activities they supported them to take part in. These included a film club, exercise sessions, manicures, visiting entertainers, cookery and visits from relatives and friends.

People using the service told us, "Yes I do exercises, but only if I feel up to it", "I do exercises sitting in my armchair, I could not do more due to my legs, but I do try", "Oh yes, I try to join in as much as I can" and "If there is a trip I will go, If I don't want to go somewhere I don't".

People using the service had a plan of care that included details of their health and personal care needs and how nurses and care staff in the service would meet these. Areas covered in people's care plans included personal care, mental health, nutrition, medicines, night care, communication, continence and end of life care. Before they left the service in June 2017, the last registered manager reviewed each area of people's care plans monthly and made changes where necessary, for example by referring people to specialist medical services where their health care needs changed.

At previous inspections we noted that care plans for personal care did not always indicate how often people should be offered a bath or shower. We discussed this with the provider and registered manager and they told us they would make sure care staff recorded in the daily care notes when people were offered a bath or shower and whether or not they accepted. At this inspection we found that the daily care notes staff completed were task based and mainly recorded information about people's personal care, nutrition and medication. We saw that the daily notes for the people we reviewed showed they had a bed wash every day but there was no mention in the notes if people were offered a bath or shower.

Some of the care plans we saw were written in a way that focused on the needs of individuals and were written in a person-centred way. They used people's names and 'I' statements to record how they wished to be supported. For example, "[Person's name] does not mind male or female carers," "[Person's name] is able to choose from the selected meal of his choice" and "I normally go to bed at 9.00pm".

When we asked care staff how they promoted independence, dignity and respect when they supported people with their personal care, they commented, "We close the door and cover the person's body with a towel. Use screens in bedrooms when providing care even if it is husband and wife", "Don't force people, if they refuse lunch, leave the person and let them eat later", "If using the commode you take the person into the toilet as there is enough room and they use it there", "Ask people to help during care and work as a team. People could wash their face or clean their teeth while I wash their back" and "Use screens, confidentiality, family to have discussions in private."

The provider had a policy and procedures for responding to complaints they received. At our inspection in February 2017 we noted that the provider needed to update these to include the current legislation and regulations. Following our inspection in August 2017 the provider sent us a copy of the policy they had reviewed in April 2017. However, this still referred to previous legislation, regulations and standards and indicated that the provider was not providing up to date information for people using the service and their relatives or representatives.

People using the service told us, "No [I haven't seen the complaints procedure], but I don't think I need to", "Yes we know how to complain and we would speak to [the provider]", "If I had any complaints I would speak to one of the head carers" and "No, I've never complained, not really. If something does upset us, we usually laugh about it". Records showed the provider responded to complaints in line with their policy and procedures.

Inadequate

Is the service well-led?

Our findings

The provider did not comply with regulations. We inspected the service in February, May and August 2017 and identified concerns with staff recruitment, staff training, the provider's management of safeguarding concerns, the management of people's medicines, the assessment of risks, the provision of activities for people using the service and the provider's arrangements for monitoring quality in the service and making improvements.

When we followed up concerns at subsequent inspections we found the registered manager the provider appointed in August 2016 had made some improvements to the management of people's medicines, the management of safeguarding concerns, the provision of activities, staff supervision and staff appraisal. However, there had been little improvement in staff recruitment, staff training and the provider's arrangements for monitoring quality and safety in the service and making improvements.

The registered manager responsible for the improvements to the service left in May 2017 and the provider has since appointed two managers. One manager left after a short time in post and the latest manager started work in the service on 21 August 2017.

This was a breach of regulation 8 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

At our last inspection we found that the provider carried out some checks and audits to monitor quality in the service but these were not always up to date or effective. For example, the provider had not identified gaps in staff training, supervision and appraisals. At this inspection we found the previous registered manager had made some improvements in the frequency of staff supervision and had also completed an annual appraisal for staff who had worked in the service for more than 12 months. However, other audits and checks failed to identify issues the provider needed to address. For example, the records of staff training were incomplete and we could not be sure staff had completed the training they needed to care for and support people using the service; health and safety audits did not identify hazards that may have presented risks to people using the service; a health and safety audit completed by the home's administrator said there had been no accidents or incidents when other records showed there had been 15 and staff recruitment records were incomplete so we could not be sure the provider had carried out robust checks to ensure staff were suitable to work with people using the service.

The service did not have a registered manager. The provider is registered with the Care Quality Commission (CQC) as an individual and has a condition of registration to have a registered manager. The provider held a City and Guilds National Vocation Qualification Level 4 Registered Manager (Adults) qualification awarded in 2005, they did not have a nursing qualification and had always appointed a qualified nurse to manage the service. The previous registered manager, who had worked at the service for 23 years, left the service following our inspection in January 2016 and another manager appointed by the provider in May 2016 left in July 2016. The provider appointed another manager in August 2016 but they did not register with the CQC until May 2017. Shortly after they registered, the manager resigned and left the service. The provider

appointed another manager in June 2017 but they resigned after three weeks in post. The manager sent CQC a copy of their resignation letter in which they stated, "The Home Manager should be given complete autonomy to manage the home. This means every aspect of the home should be under the management of the home manager. This can only be achieved by changing the current regime / culture." They went on to say that they had identified issues with staff training, staffing levels, checks and audits, repairs and redecoration but felt the provider was not willing to address these. During this inspection we found that issues the manager highlighted had been identified at previous inspections but the provider had not made the improvements that were needed to meet the fundamental standards and ensure a safe, effective service for people.

Following our last comprehensive inspection of the service in February 2017 we issued three warning notices and gave the provider up to three months to comply with regulations regarding the management of medicines, staff training and staff supervision. We carried out a focused inspection in May 2017 and found the registered manager had addressed our concerns with the management of people's medicines and the supervision of staff working in the service. The registered manager had also made some improvements to staff training but there was insufficient evidence to show they had complied with the regulations.

At this inspection we found there was no evidence to demonstrate staff received the training they needed to care for people using the service. We also found the provider did not carry out sufficient checks on staff they employed in the service and audits they carried out did not identify areas they needed to improve.

These were continuing breaches of regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

When we asked staff if they felt the service was a good place to work, they told us, "I'm very happy and comfortable to work here", "There is good communication. [The provider] and [the administrator] are supportive and always there to help" and "It is very relaxed working here. [The provider] is always there to help. If I ever get stuck there is always a nurse or care worker there to help. We work as a team".

We saw the provider had reported on the results of 15 completed survey forms they received in April 2017. While it was not clear if the surveys were completed by people using the service, their relatives, staff or visitors, 93% of respondents rated the service as excellent for a range of issues, including staffing, the environment, laundry, respect and acting on people's views and wishes.

The provider had a service development plan for 2017-2018 that included achieving full occupancy, developing a respite care service, increasing the provision of activities, introducing pet therapy and improving quality monitoring.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect. Regulation 10 (1)

The enforcement action we took:

We issued a warning notice and gave the provider one month to comply with the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service provider did not ensure staff had the training necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a)

The enforcement action we took:

We issued a warning notice and gave the provider one month to comply with the regulation.