Runwood Homes Limited

Loganberry Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 01 June 2017 and was unannounced.

Loganberry Lodge is registered to provide care and support for up to 138 people, some of whom live with a diagnosis of dementia. Care was provided across four units in the main building and a separate unit called Huckleberry located adjacent to the main building. There were 132 people in residence when we inspected.

The service had 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.

We previously inspected the service on 22 and 29 November 2016 and the service was found to be in breach of a number of the legal requirements and rated inadequate in safe. The provider put in additional management support and sent us an action plan which set out the improvements that they intended to make. This inspection was undertaken to follow up on the concerns and check that progress had been made. We found that this was an improving service but there were still areas which required further work. At this inspection we found that medication procedures were not in line with best practice ,they did not work effectively or offer adequate protection to people. The provider was due to change to a new provider and had started the process of training staff on this new system.

Staffing levels had been improved and staff were more visible however, we identified issues with the deployment of staff and staffing levels at specific times.

Safeguarding was understood by staff and we saw that the manager followed the procedure when concerns were raised. There were arrangements in place to check on staff suitability as part of the recruitment process but we have made a recommendation to further strengthen the system in place.

Risk management plans were in place to address risks to individuals such as those from skin damage and falls but further efforts were needed to ensure consistency. Checks of the building, equipment and maintenance systems were regularly undertaken to ensure people's health and safety was protected.

Staff had access to a wider range of training which meant that they were better equipped to meet the needs of people using the service however further oversight was needed to ensure that staff were putting their training into practice.

Responsibilities with regards to the Mental Capacity Act 2005 were better understood by staff. The manager told us that they were working towards reducing the restrictions on people's movement around the building.

People's nutritional needs were assessed and improvements had been made to how people were supported to eat and drink. Concerns were raised about the quality and timings of meals, however the manager assured us that they had already identified this issue and had a plan to address it.

People were supported to access ongoing healthcare support.

Staff had good relationships with those they supported however interactions were largely based around the completion of a task.

Assessments were undertaken to identify people's care and support needs. People's care and support plans contained information about people's needs and personal choices however they varied in quality. Key information had not been included for some individuals and staff were not always familiar with the contents. Monitoring systems for the delivery of personal support were not always working effectively.

There was a range of activities available for people to participate in.

The provider had a system in place for responding to people's concerns and complaints. Any issues were investigated and dealt with appropriately by the manager.

There had been improvements in managerial oversight of the service. Senior staff were more available and accessible, staff and people who used the service were positive about these changes. A range of audits had been undertaken to help identify any areas that required improvement. Changes were in the process of being made but not yet complete.

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

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.

We identified a number of breaches of regulation and you can see what action we told the provider to take

at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

Staff were not always deployed in a way that met the needs of people living in the service

Medicine administration did not always follow professional guidance.

There were systems in place to manage risks to people's welfare.

Staff were aware of what was abuse and the procedures to follow

Is the service effective?

Requires Improvement

This service was not always effective.

People raised concerns about the meals but the provider had plans to change the menus and timings. People received the support they needed at mealtimes

Staff received training to enable them support people using the service, although further efforts are needed to embed learning.

Staff had a better understanding of their responsibilities under the Mental Capacity Act.

People had access to healthcare support.

Is the service caring?

Requires Improvement

The service was not always caring

Staff were kind and people told us that they treated them with respect. However some care was task focused, and did not always meet individual needs.

People were supported to maintain relationships with friends and family and their privacy was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care and their needs were not consistently monitored.

Care plans were not all up to date and staff were not always familiar with the contents.

Activities were available which enhanced people's wellbeing.

There were systems in place to investigate and respond to complaints.

Is the service well-led?

Requires Improvement

This service was not consistently well-led.

The new leadership team had started to make changes at the service. These had been well received by staff and people using the service but were still at an early stage and change was not yet embedded.

Audits were in place and had started to identify the inconsistencies in care delivery. There was an action plan in place and targets for completion.

Loganberry Lodge

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 01 June 2017 and was unannounced. The inspection was carried out by two inspectors, a specialist advisor, two member of the pharmacy team and two experts by experience. Our specialist adviser was a nurse with expertise in end of life care and wound care. The experts by experience had experience of the needs of older people and those with a diagnosis of dementia.

Prior to our inspection we reviewed information we held about the service. This included any safeguarding referrals and statutory notification that had been sent to us. A notification is information about important events which the service is required to send us by law.
The provider had completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with the quality team at Essex County Council about their view of the care provided.

In some parts of the service people were not able to verbally communicate with us so we spent time observing care and interactions between staff and people who used the service.
We spoke with 17 people living in the service, nine relatives and 15 members of staff. We spoke with six visiting professionals as well as the management team which included the registered manager and regional manager. We reviewed 12 care and support plans, medication administration records, three recruitment files, staffing rotas and records relating to the quality and safety monitoring of the service.

Inadequate

Is the service safe?

Our findings

At the last comprehensive inspection in November 2016 we found the provider was not meeting the requirements of the law in that staffing levels were not sufficient to meet the needs of the people resident. We asked the provider to send us their action plan detailing how they would address the shortfalls we identified. They told us that they would review their levels of dependency and staffing levels. We saw that this had been undertaken and were provided details of how staffing levels were calculated. We were told that senior staff were now supernumerary and staffing levels had increased during the waking day.

However people we spoke with during the inspection continued to express concerns about the availability of staff, particularly in the evening and at night. People told us that that the service was dependent on agency staff which meant that the staff did not know them or their needs. Shortfalls in staffing meant that they did not always receive drinks in the evening and they had to wait for call bells to be answered at night.

One person told us, "Agency staff do not always know what they are supposed to be doing. Depending who is on you might get a drink and some supper but not always." One person told us that, "They had waited a long time during the night before staff came. I had to go in my pad and I didn't like that. People looked in and said that they would get someone but never came back." Another person said, "There is a terrible shortage of staff at night, there is agency it is so hard for them to understand…I try and limit my intake of water, as I have to wait a long time at night for staff." Other comments included, "They have never got enough staff – when the staff go downstairs at 5.30 there is no one up here, there should be someone up here."

Our observations on the day of our visit were that there were some improvements to the availability of staffing, particularly over the lunchtime period and we saw that staff were visible and able to support people to eat. However we observed issues with the deployment of staff on the morning of our visit and call bells were not responded to in a timely manner. One person was calling out for assistance and after the bell had rang for twenty minutes we intervened and requested that a manager provide assistance. When we checked the call bell display board in the office we saw that there were fifteen other bells waiting for a response. We visited some of the people who were calling for assistance to check that there bells were working and found that they were. Later in the day we tested the call bells and they were answered promptly by staff. We also observed that staff were not always present in the lounges and saw one person who used the service assisting another to mobilise using a wheelchair which presented some risks.

We looked at the staffing rota and saw that the majority of staff work long days which meant that there were periods were staff numbers were reduced as staff were on breaks. We spoke to the manager about our concerns and they showed checks which they had undertaken on call bell response times. These were mainly completed in the afternoon and showed that bells were responded to within a few minutes. The manager told us that visits were undertaken at night to check on staffing levels and we saw records of these unannounced visits.

We had concerns that staff were not always available to undertake housekeeping duties as we identified

issues with cleanliness during the inspection. The clinic room was dirty and some of the kitchenettes were also in need of a deep clean.

The shortfalls in staff are a continued Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection in November 2016 we found the provider was not meeting the requirements of the law in that people's medicines were not being managed safely. We found that there were continued issues with medicines. Records were not always being signed at the time of administration. There were five omissions in the medication administration records for four separate people. Handwritten additions or changes to the medication charts had not always been signed and checked by a second member of staff. There were no records of when certain medicines were due to be given, such as an injection for anaemia that is given every 3 months. There was no times recorded for medicines such as paracetamol that should be given at least four hours apart.

Medicines were stored safely in locked treatment rooms but the cupboards and refrigerator within the rooms were not locked which was not in line with the provider's medicine policy. The temperature of the refrigerators were being monitored but one of the refrigerators had 18 occasions when the maximum had been recorded above the recommended range with no evidence of any action being taken.

Medicines that require additional controls because of their potential for abuse (Controlled drugs) were not always stored appropriately and checked regularly. The controlled drug cupboard contained medicines that were not controlled drugs as well as other items such as jewellery. We found one box of medication not stored within the controlled drugs cupboard as per home policy and the stock balance of this item was incorrect.

People's allergies were clearly recorded; however there was one occasion where the information within the provider's records stated that they did not have an allergy whereas the information supplied by the pharmacy indicated that they were allergic to three different types of medicine including penicillin.

Some protocols for the administration of 'as required' medicines were available. These protocols provide guidance as to when it is appropriate to administer medicines that are not required regularly such as analgesics, inhalers or sleeping tablets. They were not in place for everyone. Glucose oral gel was prescribed for people on insulin should they require it. However, the carers were unable to administer this as they were not trained to check the blood glucose level and therefore wouldn't know whether it was appropriate to give.

If there was a choice of how much medicine to give, such as a variable dose of laxative, the records didn't always clearly show what had been administered. One steroid inhaler had been prescribed as one or two puffs to be given twice a day, this was an unclear prescription as the carer would not be able to make this judgement at the time of administration. A device called an aerochamber was not labelled with a person's name. This device helps people use their inhalers.

Medicines that were applied as patches were recorded appropriately on separate charts, although it wasn't always clear whether staff had rotated the site of patch application in line with the manufacturer's instructions. Medicines being applied topically such as creams and ointments had clear and complete records showing staff had applied them in line with the prescribing instructions. In one case the topical medicine was inappropriately stored in an unlocked bathroom cabinet and creams were not always dated on opening.

Medicines that were administered by the visiting district nurse were recorded on paper records that carers did not always know were available. These records, along with medicines were not always kept securely and we found insulin records, unlabelled insulin pens and needles in an unlocked cabinet within the dining room, which could have been accessed by any resident or visitor.

We looked at the covert administration of medicines which were being administered at the home. Covert administration involves hiding medicines in food or drink and we could not see that all the recommended health care professionals had been consulted about the medicines being crushed.

The signatory lists identifying staff signatures who were administering medicines was not accurate, the two staff who were administering medicines on the day of our inspection were not on the list. There was a programme of audit in place, both in-house and by the external pharmacy supplier, however both audits were not identifying all the issues highlighted. The registered manager told us that they were aware that the system was not working effectively and had already taken the decision to change pharmacy suppliers. This was to commence in two weeks' time and staff were currently undergoing the training with the new supplier.

The shortfalls in medication administration constitute a continued Breach of Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection in November 2016 we found the provider was not meeting the requirements of the law in that risks were not being effectively managed and staff were not provided with sufficient detail on how risks should be managed.

At this inspection we found some improvements and the service was no longer in breach of the regulations however further work was still needed to ensure consistency. Risk management plans were clearer for staff to follow, information was provided in people's care plans on the management of risks associated with pressure ulcers, malnutrition, and diabetes and mobilising. However, there were omissions, for example we observed an individual being hoisted by two staff but when we checked their records there was no moving and handling plan to guide staff on what equipment, sling and action to take to ensure a safe manoeuvre. One of the peoples whose care we looked at had the wrong type of sling in their room and we asked for this to be removed as it could be unsafe if used by staff. Pressure relieving mattress were in place to reduce the likelihood of people developing skin damage and the majority of the mattress settings were correct and appropriate for the individuals weight however we found one example where an individual who was using a mattress which was set incorrectly. We spoke to the manager about the areas we found during the inspection and they agreed to immediately address them.

Repositioning records were in place and staff were recording when they were repositioning people to reduce the likelihood of skin damage

At the last inspection we found that the falls prevention systems were not effective, at this inspection we found improvements. We looked at the records of individuals who had been identified as having a number of falls and saw that analysis of falls had been undertaken by the time and nature of the incidents. We noted that there had been a number of falls late in the evening and at night. Given the concerns expressed about staffing at these times we asked the manager to review these incidents alongside the review of staffing.

There were good systems in place to monitor people following a falling incident. For example we saw that staff checked on people for twenty four hours after the fall to ensure that there were no complications. We saw that some people had been referred to the falls prevention service for specialist advice to prevent further falls

The systems in place for the oversight of equipment and management of environmental risks were effective. We saw that checks were undertaken on fire safety equipment to ensure that it was safe to use and staff were clear about the process to follow in an emergency. There were systems in place to reduce the likelihood of equipment failure and checks were undertaken on hoist slings and lifting equipment to make sure that they were safe to use and not faulty .

Recruitment processes were in place to check on staff suitability and protect people. Examination of three staff files confirmed that relevant checks, including ID checks, criminal records check and appropriate references had been obtained on newly appointed staff. There were some anomalies between the start date and date of Disclosure and Barring Checks but we were assured by the manager that where people had started work before the results were known this was only to undertake training. The provider had recently changed the recruitment procedures and there was no longer a full employment history on file. This meant that we were unable to check whether references had been obtained from the last employer and we could not see that this was checked at interview. It is recommended that the provider checks their new procedures against the requirements.

Staff had undertaken training on how recognise signs of abuse and safeguarding. We saw from the records in the service that incidents had been recognised as safeguarding and appropriate referrals had been made. Staff said if they identified any abuse they would report to the senior management but were less clear about the role of the Local Authority safeguarding team

Requires Improvement

Is the service effective?

Our findings

At the last comprehensive inspection in November 2016 we found the provider was not meeting the requirements of the law in that training did not always equip staff with the knowledge that they needed to carry out their role in key areas such as health care, moving and handling and support to people living with dementia. At this inspection we found that some improvements had been made including the provision of a wider selection of training and increase in the amount of face to face training. The service was no longer in breach of the requirements however, we found that staff were not always putting their training into practice. For example we observed shortfalls in the management of infection control. Staff were not always following best practice, they were not always washing their hands between care tasks and not wearing protective equipment when assisting people with personal care and supporting people with meals. We found meals stored in a microwave in the late afternoon which if they had been consumed by people living at the service it would have put them at risk of food poisoning as food had not been stored according to food safety guidance. The manager told us that further observations of practice and competency checks were planned to check on staff understanding of their training.

Staff told us that they were provided with one to one supervisions which enabled them reflect on their practice and they were able to undertake additional qualifications such as the qualification credit framework. People and relatives gave us variable feedback about staff skills, comments included, "It is not bad, they get pretty good care, some of the new ones need bringing on, they have quite a big turnover of staff."

At the last comprehensive inspection in November 2016 we found the provider was not meeting the requirements of the law in that people were at risk of poor nutrition and dehydration as the delivery of food was not well organised and people's needs were not sufficiently monitored. At this inspection we found that improvements had been made and the service was no longer in breach of the legislation however there continued to be areas of concern.

The majority of the people we spoke with said the food provided could be improved. They were unhappy about the quality of food, the menu and the timings. One person said, "I have a hiatus hernia and cannot eat spicy food but today they have put two spicy meals on the menu. This is not the first time. They are not looking at what people want or need. The food has gone downhill. I asked for an omelette today and it was cold when it got to me." Another said, "We used to get support but you are lucky if you get it now. It will depend on who is on duty. We have tea served at 4:40pm but this is too early. I don't feel hungry, I have not long had my lunch but then it is a long time to wait for breakfast the next day." We spoke with the manager about the concerns that had been raised with us and they told us that they were currently dependent on cooks from an agency but were in the process of recruiting permanent staff. They were aware of the issues and had plans in place which included reorganising the timings of meals and the menu once permanent staff were in post.

Staff were observed to support people appropriately where they required one to one support with eating their meal. We observed one person get up from the table having not eaten their meal. A member of staff

noted this and brought them a fresh meal to the lounge where they were seated. Staff encouraged them to eat. Another person was observed to have eaten their savoury meal in their room but wanted to be on the move. Staff monitored them and ensure that they were later offered a pudding in the dining room which they ate. We later checked the daily records and staff had recorded appropriately the amounts that people had eaten.

The service uses the malnutrition universal scoring tool (MUST) to identify people at risk of malnourishment and we found that there was improved monitoring of people at risk. The provider carried out a monthly audit where they monitored people who had lost weight. There were actions recorded where risk had been identified and we saw referrals made to dieticians where appropriate. Recommendations made by dieticians had been recorded within care plans.

CQC is required by law to monitor the operation of the Deprivation of liberty (DoLS) and the Mental Capacity Act 2005 (MCA) which provides legal safeguarding for people who may be unable to make decisions about their care. At the last inspection we found the principles of the legislation was not well understood. At this inspection we found some improvements had been made. Staff were clearer about capacity, how it can vary and how to use best interest decisions.

The manager told us that they had made applications as required to the local authority on behalf of people where their freedom of movement had been restricted, to ensure their best interests would be assessed by those qualified to do so. At the last inspection we were concerned that some of the restrictions that were in place were not always the least restrictive. For example doors between the units had codes which meant that people could not leave the units to go onto another unit. The manager told us that they were reviewing this and we observed some doors had been opened for short periods. We observed a number of people trying to leave the units. One person told us, "There is only one thing I don't like here and it is the doors which they will not give me the number to get through. I feel like I am in a prison. It is a big thing in my mind, I want to be able to go outside and enjoy the garden but I can't. I want to feel my freedom." It was noted from a review of care records that this person was not always supported to go into the garden other than when their family supported them to do so.

We saw that a number of people had decisions they had made recorded such as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders in place which set out their wishes not to be resuscitated in the event of a cardiac arrest. These were maintained in people's care records, and we saw that there were clear arrangements in place for their access in an emergency

We looked at the covert administration of medicines which were being administered at the home. Covert administration involves hiding medicines in food or drink. While some best interests decisions were in place this was not consistent. One of the people we looked at did not have a best interest decision in place and did not have the capacity to consent. The manager agreed to immediately follow this up with the individual.

People had access to health care support when they needed it. We saw evidence of referrals to a range of health professionals such as the speech and language service, GPs and chiropodists.

Relatives told us, "They always get the doctor when needed and keep us informed", "We have no concerns, they always get the GP when needed." One person told us, "If I need a doctor they come the same day." A relative told us, "Last week I mentioned that he did not seem right and (Senior) said she had noticed and organised for him to have a urine test." We spoke to visiting health professionals as part of our inspection, they told us that there had been some improvements and the service was more responsive to people's needs.

Requires Improvement

Is the service caring?

Our findings

At the last inspection people told us that most of the staff were kind although they did not always have time to spend with them. At this inspection we found some improvements but further work is needed to ensure that people consistently receive compassionate and supportive care.

People spoke highly of individual staff, describing them as kind and hardworking. The comments included, "Staff are wonderful, they are always about and do anything for you – they are excellent staff." "Staff here do their best, nearly all of them are born abroad and they are difficult to understand and quite often I don't understand the answer they give me – they are very kind and I am confident [my relative] is well looked after."

We observed some good interactions between staff and people living in the service, and in all but one example staff spoke to people in a respectful and warm way. We observed a member of staff interacting with an individual who had been walking around with her walking frame at lunchtime, asking the way home. The member of staff very gently gave the individual a light head massage. The resident sat calmly and visibly relaxed, the member of staff spoke quietly. The resident looked relaxed and consequently ate all their lunch and dessert without leaving the table.

Other interactions were however less positive and largely limited to the completion of a task such as handing out meals or drinks. There was very little activity observed whereby staff would sit and chat with people. Discussions with staff showed that they were focused on getting tasks completed. When asked if they got involved in supporting people with taking them out into the community or involved in social activities said they did not have the time. We spoke to a visiting professional about the service and they said, "It is ok but there never seems much 1-1 interaction."

People told us that staff treated them with respect and dignity. One relative told us, "Staff are always smiling and never seen anything untoward." All the people we spoke with told us that staff always knock on their doors and keep curtains and doors closed when assisting with dressing and personal hygiene. This was supported by our observations and we saw staff knocking on doors before entering people's rooms. We heard staff showing respect and seeking consent when assisting people. One member of staff said , "Let me push your chair in, may I pop your walker over here out of the way" and "Do you mind me moving your frame?" to another person.

We saw that people were involved in making decisions about their care. We observed a staff member asking an individual if they needed wanted their bath and when they said no this was respected. Staff told us that they gave people choices and that people were actively involved in making decisions. For example, about what they wanted to wear and how they spent their time.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we found that peoples did not always receive personalised care and their needs were not always fully documented in the care plan. This meant that staff did not always receive clear direction or guidance on how to meet people's needs. At this inspection we found a variable picture, some care plans were more detailed and informative than others and peoples experience also varied. Some people were very happy with the care but others less so.

One relative told us, "I can approach staff and [my relative] has thrived and could not eat, walk or talk when he came here nearly 18 months ago and now he is happy here and staff know his mood swings." Another person told us that staff were not always aware of their preferences, "Male carers are on all the time, and when one comes in I refuse to have them and they do send a female one."

Key information was missing from care plans, one person we spoke with said, "I would not want to have a male carer washing me or bathing me. I am a widow and this would not be right for me." We looked in this person's care records alongside the unit manager and found there was no reference to gender preference. We saw that the dietician had recommended that one individual be served soft fork mashable food but when we checked the care plan this information was not recorded. We found some sponge mouth swaps in an individual's room, but when we spoke to staff they did not know how to use them and the individual's mouth was dry and encrusted. The care plan did not provide sufficient detail or guidance for staff and stated, "Staff to ensure to encourage and give frequent oral care".

We looked at the care plan and daily records of an individual who had a catheter we saw that the individuals fluid intake was low and they had to be re –catheterised on a number of occasions due to the catheter being blocked by encrustation. This situation can be eased by encouraging more fluid intake, however the individuals care plan did not provide sufficient detail on how this should be managed.

Staff were not familiar with the contents of the care plans, for example we noted that one person should have hourly checks and they should have their hearing aids in both ears to enable them to hear sounds or follow conversations. However when we checked the person, we saw that they were not wearing their hearing aids and when we asked the carer if they wore hearing aids, they said he did not know. There were no records in this individual's room to indicate that hourly checks were being made. We subsequently found a number of people's glasses and one set of false teeth in kitchen drawers and it was unclear who these belonged to and we expressed concern that people may not have access to items that they need. One relative told us, "The key carer system does not work and I would not be confident that they tell me everything I should know about [my relative]."

The manager responded to our concerns by updating people's records who we identified and told us that they intended to introduce new documentation to supplement the care plan so that staff could quickly see the salient points which were important to the individual and their family.

At the last inspection we found that people's needs were not consistently monitored and we identified

specific concerns about the provision of baths and management of risks associated with impacted bowels. At this inspection people told us that the provision of baths and showers remained a concern. We noted that bath list records where staff stated they had supported people with a bath did not relate to the daily records staff recorded and what people told us. One person told us, "I have been told there is not enough staff to give me a bath twice a week as I would like. I have not always been given the one bath a week they said I could have." One relative told us, "This is a constant complaint. We did complain and now [relative] does get one bath a week but we had to chase to get this." We spoke to staff about this and a member of staff told us, "We would not have enough staff to give people more than one bath a week if they wanted it." Care plans did not always specify people's wishes and preferences as to whether they liked a bath or shower and how often.

The record keeping regarding bowel movements was poor and we could not see how those supporting people had oversight of this. We noted from a review of 12 people's daily records that some people had gaps of up to 14 days where there had been no record of bowel movement. We had concerns as a lack of monitoring of bowel movements can mean that the indicators of constipation are missed. Constipation can cause nausea, vomiting, dehydration and increased confusion especially in those older people with Dementia

We saw that people's fluid records were monitored and totals undertaken. However where fluid consumption was below recommended levels to maintain good health and wellbeing the actions taken were not always clear.

The shortfalls we found in care monitoring constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Activities were provided to promote peoples wellbeing. On the day of our visit we saw some activities were provided in the communal areas which supported people to follow interests. Comments included, "They have a church service on Fridays and someone walks her down, [my relative] has their hair done regularly with the hairdresser, activities very engaging and saw them doing yoga last week." Other people were less positive, "We don't get a lot, not much on this side and when we go across to the main building we have to wait to be brought back, very rare anything is put on especially for us. Yesterday we did armchair exercises outside which was nice."

We saw that there was a well-stocked garden with flower beds and were told there were two people growing vegetables. We were told that there were plans to develop the activities and increase the involvement of care staff in their provision.

People and their relatives told us that their concerns were investigated. There was a complaints procedure in place for people to use to raise concerns which referred people to the regional manager, the local authority and CQC. We looked at the records of complaints and saw that concerns had been investigated and where shortfalls were found apologies were given. A relative told us that they had raised concerns which had been resolved promptly, They said they had, "Spoken to the Unit manager who sorted it quickly."

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection in November 2016 we found the provider was not meeting the requirements of the law in that we found significant shortfalls in the delivery of care and concluded that there was a lack of management oversight of this large service. At this inspection we found that improvements had been made although further work was needed to ensure that people are fully protected and receive the care they need. As a result of the shortfalls the service has been put into special measures.

Since the last inspection the provider had made a number of changes including the appointment of a new manager who has since registered with us. The new manager has experience of managing this type of service and was previously manager of another of the provider's services.

The manager was supported by two newly appointed deputy managers who worked on a supernumerary basis which meant that they were better able to focus on how care was delivered. Unit managers were also in place and they had oversight of the care in the individual units. Some of the appointments had only relatively recently been made and the new structure was still embedding, however lines of responsibilities were much clearer

Staff morale was improving and staff spoke positively about the changes to the management arrangements, one member of staff told us," [The manager] is new and is making some good changes, she is good with the staff and I feel well supported ". Staff told us that regular staff meetings were being held and we saw from the minutes that there was dialogue with staff about how to drive improvements at the service.

Relatives and peoples using the service were also more positive and one person told us, "It is a lot better since the new manager came, she is more approachable and she gets things done." Another person told us, "Positives outweigh the negatives and it has got better, the overall ambiance is better since the new manager came and there is a better atmosphere." People told us that a meeting had been held which was described as, "Open and honest, "and their concerns had been listened to and taken on board.

The manager described some of the changes they were making at the service which had included some specific training to address areas which had been identified and observations of practice. They told us that they had previously been involved in the prosper scheme which is a scheme run by the local authority to support care homes and was planning to implement the learning at the service. The manager showed us some of the systems they had introduced to make it clearer for staff and the data that they collected on a monthly basis. The manager was able to outline the action that they had taken in response to issues that they had identified such as the appointment of specific staff as champions to drive further change

The manager and the regional operational staff undertook a number of audits to check on the care as part of the provider's quality auditing system. These looked at a range of areas including care plans, infection control, medication and health and safety. These audits had identified some but not all of the issues that we found, for example they had not identified the shortfalls in cleanliness or staffing. Improvement plans were in place and we saw for example that a decision had been made to change the medication supplier. Where

areas had been identified there were clear timescales for improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Peoples needs were not always monitored effectively or their wishes taken into account

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medication was not always being managed in a safe way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably competent staff were not always available to support people