Yourcare Limited

Knowle 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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This unannounced inspection took place on 19 November 2014.

Knowle House Nursing Home provides accommodation and nursing care for up to 35 older people who have nursing needs. The home supported people who were living with the early stages of dementia. The home has 27 bedrooms with seven of these being shared rooms. There were 26 people living at the home.

The home had not had a registered manager since September 2012. The provider told us they were in the process of recruiting for this position and as an interim measure they had an acting manager to oversee the home. 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.

People and their relatives spoke highly of the staff and the home. They told us staff were kind and respectful and supported them to make day to day choices. People were not provided with opportunities to be actively involved in decisions about their care and the home. We have made a recommendation about involving people in decisions about their care and the home.

There were policies and procedures regarding the safeguarding of adults at risk, however some staff lacked

Summary of findings

knowledge and understanding of what safeguarding meant for people. Where safeguarding incidents had occurred the home had not used these as an opportunity to learn and inform future practice.

Medicines were not always given as prescribed because the home had run out of stock and had not obtained prescribed medicines for people. There was a lack of recording of medicine errors and the acting manager did not always recognise these. There was no evidence that any planning or action had been taken to prevent reoccurrence of medicines errors. The provider was unable to demonstrate that staff were appropriately trained and competent in medicines management. There was a lack of guidance for people who were prescribed 'as required' medicines which are taken on an occasional basis.

Some risk assessments for people lacked detail or were incomplete. Whilst some care plans provided detailed information to guide staff about the support a person needed, others were not always personalised and did not provide sufficient guidance.

Staff lacked an understanding of the Mental Capacity Act 2005 and as such the principles of this had not been applied in full. Where people were deemed to lack capacity this was not based on their ability to make specific decisions and implied they could not make any decisions for themselves. There was no evidence of 'best interests' decision making processes being followed. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Three applications for DoLS had been made. The provider was aware of when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

The home did not effectively review information gathered from investigations and quality audits. Staff were not consistently provided with opportunities to discuss issues of concern, look at practice and discuss improvements.

There were enough staff on duty to meet people's needs. Appropriate checks had been undertaken, however, where the Disclosure and Barring Service (DBS) checks identified concerns, no further action to explore these to ensure there were no risks for people living at the home had been taken. The provider was unaware of the concerns raised within the checks.

People had no concerns or complaints about the home and would speak to the manager or a relative if they did. When complaints had been received these had been dealt with appropriately and action had been taken. However, the provider had not identified a pattern and could not demonstrate learning. We have made a recommendation about the learning from complaints.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe. People were placed at risk because staff did not know how to recognise and report abuse. There were no systems in place to encourage learning from safeguarding incidents and inform future practice. Risk assessments associated with people's needs had not always been undertaken. Clear information about risks and how these are to be managed was not available.

People did not always receive their medicines as prescribed and there were inadequate arrangements for reviewing errors and implementing corrective action.

Staffing levels were sufficient to meet the needs of people and the provider carried out appropriate recruitment checks. However when these raised concerns no further action was taken to explore the concerns or take appropriate action.

Is the service effective?

Requires Improvement

The service was not effective. Staff did not understand the principles of the Mental Capacity Act 2005 and they had not been applied correctly. Consent was sought form people's relatives without evidence they had the legal authority to provide it.

Staff had not received sufficient and regular training to ensure they had the skills to meet the needs of people.

People enjoyed the food in the home and there was always a choice at each mealtime. Meals were provided for specific dietary needs, however monitoring of nutritional intake was not effective. It was not always clear why people were receiving a specific type of diet. Health needs were reviewed and as appropriate by other professionals.

Is the service caring?

Requires Improvement

The service was not always caring. People were not consistently provided with opportunities to be actively involved in decisions about their care and support.

People were positive about the care they received and this was supported by our observations. Staff treated people with kindness and respected their privacy and dignity. Staff demonstrated a good understanding of privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive. People had their needs assessed before moving into the home, however, care plans were not always developed to ensure all the persons needs could be met. Care plans had either not been completed or lacked the appropriate guidance for staff.

Summary of findings

The home dealt with complaints in line with their policy and records showed the outcome of investigations was shared with the complainant. However, we could not be assured learning from complaints took place and arrangements for feedback from people was always acted on.

Is the service well-led?

Inadequate

The service was not well-led. The service has been without a registered manager for two years and has had several changes in management. There was a lack of clear leadership and understanding of the differing roles and responsibilities of the provider, the acting manager and staff.

The provider was not carrying out effective checks to ensure they provided a quality service to people and to ensure people received safe and effective care. Where they had gathered useful information through surveys and audits, this information had not been used to identify improvements and make changes to practice.

Staff were not consistently provided with opportunities to discuss issues of concern, look at their practice and discuss improvements.

Knowle 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.

The inspection visit took place on 19 November 2014 and was unannounced.

The inspection team consisted of an inspector; a specialist nursing advisor 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 service. The Expert by Experience at this inspection had previous experience of running a care home for older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information in the PIR along with information we held about the home, including notifications they had sent us. A notification is information about important events the service is required to send us by law. We contacted three social care professionals and one healthcare professional to obtain their views about the care provided in the home.

During the visit we spoke with six people living at Knowle House Nursing Home and three relatives. We spoke with nine staff including the acting manager, nurses, care staff, a chef, an activities co-ordinator and the administrator. We also spoke with the provider.

We observed care and support in communal areas and also looked at the kitchen and 11 people's bedrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for six people, the recruitment, training and induction records for seven staff employed at the home, 12 people's medication records and the quality assurance audits the home completed.

Following our inspection we asked the service to send us additional information in particular policies relating to staff, quality and contingency planning, the staff training plan and information about who delivers the 'in- house' training and their competence to do so. We also requested information about any action plans developed as a result of the quality surveys the provider had undertaken with staff and relatives. We received all the information we requested.

Inadequate

Is the service safe?

Our findings

Although people told us they felt safe in the home, some staff's understanding of safeguarding people was inadequate. Staff said they would report any concerns about people's safety to the manager. However, two staff demonstrated a lack of knowledge and understanding about safeguarding. One told us "It's making sure infection control is right". A second staff member told us, "It's to help people," but was not able to state how. Staff had received training however; they were unable to demonstrate how they would put their learning into practice and protect people from potential abuse. People may be at risk because not all staff recognised and understood safeguarding.

Staff were confident the nursing staff would respond appropriately to any concerns about people's safety. The safeguarding policy provided guidance to recognising abuse and reporting concerns. It detailed concerns should be reported to the provider who would investigate and decide on action to be taken. If the provider considered the concerns "very minor" they would assess the situation and they would deal with this internally. The policy did not define "minor" and therefore people may be at risk as the appropriate professionals may not be contacted regarding potential safeguarding issues. A safeguarding investigation was being undertaken by the Local Authority responsible for investigating safeguarding matters at the time of our inspection. The acting manager had limited knowledge of this and had not been involved in the investigation. Nursing staff had not met to discuss the concerns and look at any practice issues. There was no evidence the home had undertaken an investigation and we could not see what action had been taken to prevent an incident of this nature reoccurring. The home's policy stated "incidents of alleged/ confirmed abuse will be logged and reviewed at the Quality management review meetings for possible adverse trends". The acting manager did not know about these review meetings or how they were used to ensure future incidents were prevented and practice improved. People were at risk because information about safeguarding incidents was not used to learn from and inform future practice.

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

People said staff helped them to take their medicines and they received these when needed. Medicines Administration Records (MAR) for 11 of 12 records showed medicines had been administered as prescribed. However one person had not been given one medicine for four days because the provider had run out of stock. This had not been reported in line with the home's policy. There was no record of an investigation into the cause of this and actions to be taken to reduce the risk of this reoccurring. The acting manager did not consider this a medicines error. The lack of stock of this medicine meant the person's health may be placed at risk as they were not receiving their prescribed medicines. People may be at risk as medicine errors were not always recognised and appropriate plans were not implemented to reduce the risk of recurrence.

There were no care plans in place relating to the administration of 'as required' medicines only a record on the person's MAR. There was no clear guidance for staff about when a person may require these types of medicines. The acting manager was not aware of which people in the home were receiving 'as required' medicines. There was a risk people would not receive their medicines appropriately and at a time when they need it.

Qualified nurses were responsible for administering medicines. The training matrix did not include the administration of medicines. There were medicine competency assessments undertaken by the nurses, however, none had been done in the last 24 months and the acting manager was unable to show us any records. People may not receive their medicines from staff that were appropriately trained and competent to do so.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations**.**

Observations of the support people received to take their medicines were positive and this was carried out in a timely and respectful manner. The home had appropriate policies and procedures in place for the management of medicines. Storage arrangements for medicines were secure. We checked the storage and administration of controlled drugs and found this was undertaken in line with appropriate legislation.

People were at risk of receiving unsafe or inappropriate care because risks associated with their needs had not been clearly identified and plans for managing and reducing these risks had not been implemented. For three

Inadequate

Is the service safe?

people who had a diagnosed health condition there were no risk assessments to support the care plan. There was no guidance about the risks associated with the health condition and how this should be managed.

There was a business continuity plan in place for foreseeable emergencies such as fire, flood and power failure so that staff knew what action to take to protect people in these circumstances. However, individual risk assessments were not always fully completed and did not provide sufficient guidance for staff. For example, one person's personal emergency home evacuation plan had not been completed and there was no guidance available for staff or other emergency personnel about the support they would need in the event of an emergency. This placed this person and others at risk as without clear guidance response times in an emergency may be delayed.

One person was being cared for in bed however the risks associated with staying in bed had not been fully assessed and the plan of care provided was inadequate. A care plan told staff to check the person hourly but did not provide any other guidance about if the person required support to reposition and how frequently this should be done. We saw staff were completing a "turning chart" (this is a document which records when staff have supported a person to reposition themselves. Regular repositioning will reduce the risk of developing pressure sores.) This chart stated the person needed support to reposition every four hours, however on review of these records over four days we saw that this did not happen consistently. On one occasion the records showed this person was not supported to reposition for eight and a half hours; on another occasion for 10 hours. There was a risk of this person developing health complications because the risks associated with remaining in bed had not been appropriately assessed and the guidance on the turning chart was not being followed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Staff recruitment practices at the home did not fully protect people from being supported by unsuitable staff. The appropriate checks had been undertaken in line with the home's policy. However, where the Disclosure and Barring Service (DBS) checks identified concerns, no further action to explore these to ensure there were no risks for people living at the home had been taken. DBS checks help employers make safer recruitment decisions and help prevent unsuitable people from working with people who use care and support services. Whilst the home was undertaking the appropriate recruitment checks, where information indicated further investigation of risks to people was required this had not been done. Therefore recruitment practices were not always thorough to ensure people were supported by staff that were suitable to work with them.

People we spoke with told us they felt there were enough staff available to give them the support they needed and no concerns were raised about the staffing levels. The acting manager told us the home operated at one nurse and five carers in the morning, one nurse and four carers in the afternoon and one nurse and three carers at night. In addition the provider also employed an activities coordinator who worked four days a week. They also employed maintenance, kitchen and laundry staff. The staff rotas covering a period of four weeks indicated that the staffing levels had been supplied on most days. However, there were five shifts when the staffing level had dropped below this. The provider and acting manager told us if additional staffing was needed this would be supplied based on people's individual needs. Throughout the inspection we observed there were enough staff to meet people's needs and respond to their requests promptly. Staff we spoke with also felt staffing levels were sufficient to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

One healthcare professional told us when they had been present they had seen staff gaining people's consent before providing support. Three people said they had not been involved in making decisions about their care plan. Whereas others told us their care plan had been prepared with involvement from their relatives.

Whilst consent was sought for the use of photographs for treatment purposes and for staff to enter people's rooms without knocking, this was not always from someone who had the legal authority to provide this. The principles of the Mental Capacity Act (MCA) 2005 were not applied correctly. Staff lacked knowledge and understanding regarding the Mental Capacity Act 2005 and the use of the Deprivation of Liberty Safeguards (DoLS).

Appropriate consent had not been gained for two people living in the home. Consent forms regarding the use of photographs for treatment purposes, and, for staff to enter rooms without knocking in an emergency, which had been signed by relatives. We found no evidence these relatives had the legal authority to provide this consent and the acting manager was unable to tell us either. This was in breach of the provider's policy which stated if a person lacks capacity to give or withhold consent for themselves, no one else can give consent on a person's behalf.

Twenty of 30 staff had not received training in the Mental Capacity Act 2005 and staff demonstrated a limited understanding of their role and responsibilities with this. Mental Capacity assessments had been completed for two people, however they did not identify the decision the assessment was being completed for. They suggested people lacked the ability to make decisions in general and were not time or decision specific. There was a risk staff would assume people were unable to make any decisions for themselves as the assessments were not specific to the actual care or treatment decisions that the person may need to make. No record was available of what decisions they could or could not make or how staff should support them with decision making. We also found no evidence of any best interests' decisions being made. Best interest decisions are those taken on behalf of a person, with relevant professionals and relatives involved.

The rights of people to make decisions was not fully protected.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider told us three applications for DoLS had been made. The provider was aware of when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Staff undertook an induction when they first started work at the home. This included how to support people with personal care and the use of moving and handling equipment. Training was through watching DVD's on a variety of subjects which the staff said they found helpful. Staff had not always received relevant training and training received was not kept up to date. For example, the training plan showed 27 staff had not received first aid training, 21 had not received training in the role of the care worker and 23 had not received equality and diversity training. The home supported a number of people who were living with dementia however no staff had received training dementia awareness. In addition the home also supported people with a diagnosis of diabetes and no staff had received training in this area of need. A nurse told us about the care staff, "They haven't received specific training but know to let the nurse know if anything changes". Of five staff records, three had received a supervision meeting in 2014, whereas two had not received this support for over a year. People were at risk because staff had not received appropriate training and support to ensure they had the skills to meet people's needs.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activates) Regulations 2010.

People were complimentary about the food that was provided. Menus were displayed around the home. This provided a choice of food options and snacks, biscuits and drinks were offered between meals. Staff encouraged people with their nutrition and hydration. Where people required support this we observed staff providing this. Staff sat with people and encouraged them throughout their meal. People were weighed regularly and if this was not possible nursing staff measured people's arm circumference as a way of identifying any weight loss. The acting manager told us if required people would be referred to a dietician for support.

Requires Improvement

Is the service effective?

Care plans were in place for people's nutritional needs. These provided basic information and did not give clear guidance to staff about the person's likes/dislikes or target food and fluid intake. For example, one person's plan stated they were at risk of self-neglect as they were reluctant to eat and drink. They were receiving a pureed diet and their weight was being monitored. It was unclear why a pureed diet was being provided and staff gave different reasons. This may have been inappropriate to their needs and not supportive of a good dietary intake. Food charts were in place and whilst these recorded the meal the person had been given, they did not record the amount provided or the actual amount consumed. Therefore clear monitoring of this person's nutritional intake would not be effective. There was no information to guide staff about their ideal fluid intake. Fluid charts for this person for the two days prior to our inspection recorded they had consumed very little fluid. No action had been taken to investigate any implications of dehydration for this person. The lack of planning, review and evaluation of recorded information meant this person may be at risk of complications associated with malnutrition and dehydration.

People had access to a range of health professionals including opticians, dentists, GP and specialist nurses. One health care professional told us the home made timely and appropriate referrals to them for support. The staff provided the information they required. Everyone we spoke with told us access to a nurse or doctor was readily available if needed.

Requires Improvement

Is the service caring?

Our findings

People with said they were happy with the care provided and spoke highly of the home. One person told us, "I wouldn't want to go anywhere else". A second told us, "I am happy with the way they look after me". A relative we spoke with told us, "It's very good, the people are very friendly and they look after my [relative] very well. My [relative] is very happy here". Everyone we spoke with told us they would recommend the home to a friend. No one had any concerns about the home of the care they received.

Care records included information about what name people preferred to be known by, and we saw that staff used these names. One person had written their life story so that staff could understand more about them. However, some care plans were task based and contained very little information about people's preferences or personal history. For example, one person often refused to eat and drink but there was no information about their likes, dislikes and there was no guidance about alternatives staff should offer. When speaking with staff they showed a good knowledge of people's needs and their preferences.

People were not consistently involved in decisions about the running of the home as well as their own care. Three of six people did not recall being involved in developing their care plan and no one could recall any reviews of their care plan taking place. Others knew a care plan had been prepared with the input of their families and relatives confirmed this. People were confident they were listened to and that staff responded to their requests. People said they made choices about how they spent their days and staff knew the support they needed.

Throughout the day people had unrestricted access to their bedrooms and some people chose to spend part of the day in their room. Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home. Bedroom doors were always kept closed when people were being supported with personal care. Staff used screens where needed and provided people with explanations about what needed to be done. People said staff respected their privacy and dignity and the staff understood the principles of this.

Interactions between staff and people living in the home were relaxed. The staff appeared confident in their approach to people. People that were able to move independently had free movement around the home with people choosing where to sit and spend their recreational time. However, the layout of the lounge area within the home did not promote a good social environment. All chairs were lined up around the edges of the room with two large TVs on the wall. We observed staff supporting people throughout the day. Staff interacted positively with people, showing them kindness, patience and respect. On one occasion we heard a staff member talking to a person about a newspaper they had requested. They told the person they had left this in their room with a cup of tea. The person said, "Just how I like it". People were treated with kindness and respect.

We recommend the service seeks advice and guidance from a reputable source, about supporting people to express their views and actively involving them in decisions about their care and support.

Requires Improvement

Is the service responsive?

Our findings

People were happy with the care they received and were confident that if their needs changed these would be responded to. They spoke highly of staff and said staff knew them well and how they wanted to be supported. They told us if the needed to see a doctor because they were unwell, staff always arranged this.

Before people moved into the home pre admission assessments were carried out. This involved talking to them, their relatives and other as appropriate professionals to identify their needs, wants, wishes and plan their care. This information was used to develop care plans for people. Care plans provided information about some of the person's needs, however we found gaps in some areas where we could not see how the person's needs had been appropriately planned for. One person's assessment identified a previous operation which may have implications on their health. There was no care plan or risk assessment regarding this in their care records. There was no information about whether this may be a risk to the person should they develop an infection and how this should be monitored or treated by staff. A second person's emotional needs care plan had not been updated to reflect the support they required following a bereavement. Staff were unable to tell us the support this person required. The lack of clear planning meant people's needs may not be met in an appropriate way.

Three people who had a diagnosis of diabetes had care plans in place, however they lacked sufficient information for staff to guide them about how to monitor and respond to any change or deterioration of their health condition. These care plans contained no information about the person's usual blood sugar levels or what to do if these were outside of safe levels. It was unclear how a risk to their health may be identified. Whilst plans advised staff to monitor for signs of unsafe blood sugar levels, two records gave no information about what staff should look for. They did not provide any information to staff about other associated complications of diabetes and how this should be monitored. Diabetes can cause difficulties with circulation especially in the feet. The care plans provided no information to staff about how to monitor if the person was suffering any other effects of this condition and therefore there was no guidance about when they may need specialist input. The acting manager was unable to explain what action they may take if they were concerned by a person blood sugar levels, other than to recheck them at a later time. A lack of clear planning and guidance means that people are at risk of receiving inappropriate care or treatment that does not meet their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Other plans of care contained a good level of detail and guidance about the support people needed. Four people's mobility care plans contained detailed information about what the person was able to do and where they required support. They detailed the moving and handling equipment that staff must use and where bed rails were required associated risk assessments had been completed. For one person their nutrition care plan explained how their nutrition was supported by a Percutaneous endoscopic gastrostomy (PEG) feed. This is a tube which goes into a person stomach used to provide them with a means of nutritional intake when oral intake is not adequate. This plan provided clear information about when this was started, how long for and how the person should be positioned. It provided clear guidance about how to manage the PEG tube in between feeds and how to ensure the site was kept clean to prevent infection.

Care records were reviewed by a nurse and staff were made aware of any changes to people's needs and care through handover. No records of handover were kept however we observed these happened at the change of each shift.

The provider employed an activities co-ordinator and a plan of activities was on display around the home. This staff member encouraged people to join if they wished. We saw some people undertaking activities on their own such as drawing, reading books and the newspaper, watching TV or listening to music. For those that chose to join in, group activities were held by the activities coordinator in the conservatory area. Several times throughout the day care staff were either sitting or standing in the lounge area but were not engaging with people. Care staff did not spend time with people outside direct care tasks. Opportunities throughout the day to offer people activities and social engagement were missed and we could not be confident people's social welfare needs were met.

We asked the provider how they actively involved people and gained feedback. They told us they held quarterly resident meetings. One person told us they knew these meetings had happened in the past but we saw these were

Requires Improvement

Is the service responsive?

infrequent. Minutes of a resident and relative meeting and people had the opportunity to comment about the home. However, this was dated January 2014 and no further meetings had taken place. People did not recall having their views sought. Relative feedback had been sought via surveys. The 2014 analysis showed people were generally satisfied with the service. However comments had been made about improvements relatives would like to see. These included, "More time should be given to staff to talk to residents," and, "Manager doesn't seem to stay very long". An action plan had not been developed at the time of our inspection. Two weeks after our inspection we were sent an action plan from the results of this feedback. Whilst this highlighted the concerns and named the responsible person/people for actioning it did not provide any detail about actions to be taken or timescale for completion.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations**.**

There was no information displayed in the home to guide people with how to make a complaint. People had no concerns about the home and were confident if they raised any these would be listened to and acted upon. Staff were confident any concerns raised would be dealt with, and one said they would be informed by the nurse in charge of any changes to be made as a result. The provider had received a number of complaints in the last 12 months. The complaints had been investigated and responded to within a reasonable timescale and the complainant had been given details of the outcome of their complaint.

Staff and the acting manager were unable to tell us how complaints were used as an opportunity for learning. The acting manager told us complaints were addresses but could not tell us of any changes as a result. One staff member was not aware of any changes that had been made following complaints.

We recommend that the service seek advice and guidance from a reputable source, about the learning from complaints.

Inadequate

Is the service well-led?

Our findings

People, relatives and staff spoke very positively about the home. No one had any concerns about the care or the service they were receiving. People and relatives were confident they were listened to and that staff would act upon their concerns if they had any.

The service had no registered manager since 2012. The management of the service had not been stable in recent years due to changes of manager. We were aware of two previous managers since this time. A long standing member of staff had been appointed as acting manager during the times when the home was without a permanent manager. This person did not wish to become the registered manager and did not appear to understand their role and responsibilities as a manager. For example, they had not been involved in a recent safeguarding matter, they were not aware they were required to monitor recruitment checks. They told they did not undertake staff meetings and these did not take place when a manager was not present.

Staff were not actively and consistently involved in developing the service. Records showed staff meetings had not taken place when a permanent manager was in post. The acting manager confirmed these meetings did not take place without a permanent manager and they did not hold these. Meetings, involving nursing staff to discuss any issues, identify any concerns and put plans into place to address these did not take place. Following our inspection the provider sent us an action plan which stated the home would start these and the first meeting would take place on 26 November 2014. Staff did not have the opportunities to meet and discuss any concerns regarding the home and people's care to help inform practice, for the benefit of the service.

Staff feedback was sought via annual surveys. The analysis for 2014 showed 88% of staff felt part of a team and 94 % said they felt training opportunities were good. However 50% of staff said they do not always feel supported in their role and 51% felt management did not always provide guidance and support. Comments made about improvements staff would like to see included "More staff meetings to be able to talk about issues to improve communication," and, "A manager and regular staff". No action plan had been completed to address the concerns raised by staff. We could not be assured staff feedback was acknowledged and acted upon, for the benefit of the service.

The provider explained the ethos of the service and how it was for people to have the best care and do the things they enjoyed. This was echoed by staff and the acting manager throughout the inspection. There was a staff handbook which included guidance and statements that staff should treat people in a dignified and respectful manner. Staff said their job was to give the best care possible to people. They said they would raise concerns if they felt it was needed and were confident these would be addressed. However, one staff member told us they felt nursing staff did not listen and act on their concerns. The provider told us they encouraged staff to speak up and raise concerns in order to create an open culture. People did not know who was in charge of the home however the relationships they had built with staff meant they felt comfortable raising issues with the. Everyone said they had no concerns and were confident action would be taken if they had. The provider recognised the need to recruit a registered manager to support the service to strive for improvement and excellent. They told us this was an area of focus for them.

We asked the provider how they monitored the quality of the service provided. The provider told us they visited weekly however did not carry out any audits. They said audits took place however they did not know what these had identified or how they were used to make improvements. The provider said "I don't look at audits, I deal with finance and buildings. I'm not involved in care. My wife deals with that side of things". This was one of the providers.

Audits were not effectively identifying areas of the home which required improvement. The provider said supervisions audits were carried out however, no records of these were available and supervisions had not carried out regularly for all staff. Weekly drug audits were completed by nursing staff. Where concerns were identified no actions were recorded. Patterns were not identified and we could not see how they were used to make improvements to the service. For example, on three occasions since March 2014 these recorded that medicines had run out of stock. The provider had not identified this pattern and no action had been taken to address this, to ensure no impact for people.

Inadequate

Is the service well-led?

Audits were not consistently carried out and were not always effective in identifying areas the home needed to make improvements in, meaning people may not receive a service that meets all their needs.

Complaints were logged and dealt with on an individual basis. The Provider Information Return told us that all complaints had been analysed and no trends or patterns had been identified, however we found three separate complaints which related to people's missing property, these were dated March 2014, June 2014 and September 2014. We could not see the home had identified a pattern and could see no action had been taken to look at the cause of repeated concerns.

A lack of consistent management and clarity of the responsibilities of the acting manager means management oversight of information gathered during audits, surveys, complaints, safeguarding concerns and incidents was not fully effective. As such improvements to the service were not always recognised and action taken.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations**.**

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 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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that service users were protected against the risks of receiving care or treatment that is unsafe and inappropriate. People's needs had not been fully assessed. Planning of care did not meet the needs of people. Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare. Regulation 9(1)(a)(b)(i)(ii)(2).

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 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not make sure suitable arrangements were in place to safeguard service users against the risk of abuse. They had not taken reasonable steps to identify abuse and prevent it before it occurs. Regulation 11(1)(a)

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 2008 (Regulated Activities) Regulations 2010 Management of medicines Service users were not protected against the risk associated with the unsafe use and management of medicines because the registered person did not have appropriate arrangements in place for the recording, using and safe administration of medicines. Regulation 13

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users, or the consent of another person who is able to lawfully provide such consent. Where people did not have capacity to consent the registered person had not ensured they acted in accordance with legal requirements. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to train and supervise staff to ensure they are able to deliver care and treatment safely and to an appropriate standard. Regulation 23(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not ensure that people were protected against the risk of inappropriate or unsafe care and treatment because they did not have an effective system in place to regularly monitor and assess the quality of the service provided. 10(1)(a)(2)(b)(i)(e)