Care Quality Commission

Acegold Ltd
Hollycroft Care 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

Hollycroft Care Home provides accommodation and personal care for up to 30 older people at any one time. On the date of the inspection, 28th October 2014, 15 people were living in the service.

At the last inspection in March 2014 the home met all the regulations we looked at.

A registered manager was not in place. 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 and associated Regulations about how the service is run. There was a newly appointed home manager in post. They told us they would apply for the registered manager post immediately.

Some incidents of abuse were not properly reported and investigated. This meant that appropriate action was not always taken to protect people from harm. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Consent was not always sought correctly. Care records showed people's capacity was not assessed under the Mental Capacity Act 2005 (MCA) which meant there was a risk their rights were not protected. We found one person

Summary of findings

had their medicines administered covertly, but there was no evidence their mental capacity had been assessed or the decision had been made in the person's best interest. The service was not meeting the requirements of the Deprivation of Liberty Safeguards. (DoLS). Restrictions on people's liberties had not been considered despite the service restricting people's access out of the building. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staffing levels were not always sufficient to keep people safe. There were times in the morning and at lunchtime when we observed there were insufficient staff to meet people's needs.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plan documentation did not always reflect people's needs, was inconsistently completed and it was often difficult to find key information. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found staff did not demonstrate a thorough understanding of some subjects such as safeguarding and DoLS which was delivered via the computer based system indicating the training was not fit for purpose. In some cases, training records were missing which meant there was no evidence staff had received appropriate training. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some care plans contained detailed information which showed people's needs had been thoroughly assessed to allow staff to deliver appropriate care. However this was not consistently applied and we found other care plans were missing key assessments and had not been updated following people's changing needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

A range of activities were on offer. These included activities personalised to people's individual needs. People reported activities were good and said they choice in the activities they got involved in.

The premises was safely managed. Appropriate communal space was available as well as a well maintained garden area. Checks on equipment were undertaken to help keep people safe.

Staff, people and relatives spoke positively about the new manager and said they had made a number of improvements in the short time they had been in post. We saw evidence which confirmed this was the case, for example around improving staff morale and communication between the staff groups. However further work was required to the services quality assurance system to ensure it proactively identified and rectified care quality issues. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

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 

The service was not safe. Staffing levels did not consistently meet people's needs. During the morning and at lunchtime there were times when there were insufficient staff to meet people's individual needs.

Some incidents were not properly reported and investigated. This meant that appropriate action was not always taken to protect people from harm.

Referrals had not been made to the local authority safeguarding unit where risks to people had been identified.

Risk assessments were not consistently completed on a monthly basis in line with the requirements stated in people's care plans. This meant that emerging risks to people may not be promptly identified.

Is the service effective?

Requires Improvement 

The service was not consistently effective. People's capacity was not assessed in line with the requirements of the Mental Capacity Act 2005 (MCA) which meant there was a risk their rights were not protected. The service was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) as appropriate steps had not been taken to review people's capacity and any restrictions placed on them to determine if there were any unlawful restrictions.

People and their relatives spoke positively about the service and said staff knew how to provide effective care. People were given choice as to events in their daily lives, for example what activities they wanted to do and what food they wanted.

A range of training was provided to staff, which consisted of a mixture of face to face training and e-learning. However, staff said e-learning training was poor and we found staff did not have a good understanding of some e-learning topics such as safeguarding. Documentation which confirmed the training people received on induction was not consistently completed.

Is the service caring?

Requires Improvement 

The service was not consistently caring. People and their relatives said staff were kind and compassionate and understood their individual needs. We observed interactions and found they were mostly positive between people and staff. However, we saw some negative interactions, such as staff breaking off from supporting someone with their meal to attend to other matters.

Summary of findings

Care plan documentation was not user friendly and did not promote involvement of people in the care planning process. Some sections relating to likes and dislikes and cultural preferences were poorly completed which meant there was a risk staff did not have sufficient information to provide personalised care.

People and relatives praised the staff group and management and said they felt listened to by them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Care plan documentation was inconsistently completed and it was often difficult to find relevant information. Care plans did not always reflect people's current needs.

A range of activities were on offer. These included activities personalised to people's individual needs. People reported activities were good and said they had a choice in the activities they got involved in.

A complaints system was in place and people and staff said the manager was effective in dealing with any issues raised.

Is the service well-led?

Inadequate

The service was not consistently well led. CQC had not been notified of all notifiable incidents including serious injury notifications and abuse. A registered manager was not in place.

Some audits were undertaken, however the quality assurance system was not sufficiently robust to identify and rectify the issues we found during the inspection.

People and staff spoke positively about the new manager. We saw they had made a range of improvements in the short time in post. This included addressing poor staff morale and team work and addressing performance issues to improve the quality of care provided.

Hollycroft Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014. At the last inspection in March 2014 the home met all the regulations we looked at.

The inspection took place on 28th October 2014 and was unannounced. The inspection team consisted of two adult social care 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.

We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people who used the service, two relatives, four members of staff, and the newly appointed home manager. We spent time observing care and support being delivered. We looked at seven people's care records and other records which related to the management of the service such as training records and policies and procedures.

We did not ask the provider to complete 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 the inspection, we reviewed all the information held about the provider. We contacted the local authority commissioning and safeguarding team and the local healthwatch organisation to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health care professionals who regularly visited the service.

Is the service safe?

Our findings

People and their relatives told us they felt safe in the service and did not raise any concerns with us over safety. For example, one person said, "I am very lucky to be here, they are all very nice and kind," and a relative told us, "[person] is safe and settled here and staff have made [person] less agitated."

We saw safeguarding and whistleblowing policies were in place. Staff we spoke with had an understanding of what constituted abuse but did not have a clear understanding of the correct procedure to follow should abuse be identified, for example the organisations responsible and how to report to them. This meant there was a risk appropriate action would not always be taken by staff in the absence of the manager. The manager was unable to locate a copy of the local authority safeguarding procedures which meant there was a risk that the service was not following agreed local protocol as this information was not readily available. On looking at people's daily records we found incidents which put people at risk. These included one person going into another person's room and taking their personal possessions. In another incident a person who used the service had attempted to assist an immobile person out of a chair. Following this incident, staff highlighted a person was at risk and spoke to healthcare professionals; however no safeguarding referral had been made. If safeguarding incidents are not reported, the local authority cannot make a judgement as to whether further action is needed to protect people from harm. There was no evidence of any actions taken to protect people from harm following these incidents, for example, updating care plans with clear plans of action. These incidents had not been referred to the local authority safeguarding team.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because appropriate action was not taken to protect people from abuse.

We found an inconsistent approach to incident management which meant that appropriate action was not always taken following incidents. A computerised incident management system was present which staff used to report incidents; these were then investigated by management. However, we found a number of incidents had not been reported on the system which meant they had not been investigated. These included a resident "punching and hitting a staff member" and "throwing cup of water over another resident." There was therefore no evidence these incidents had been reported, analysed and managed to reduce the risk of harm.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Systems were in place to ensure medicines were administered safely. We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. We found that records were complete and that people had received the medication they had been prescribed. Information was available for staff to assist in giving "as required" medication and we found appropriate records were in place for this type of medication. We asked staff about the safe handling of medicines. Answers given demonstrated that staff members knew of the correct procedure. However, we observed that this did not consistently translate into safe practice. We saw that one person was administered an effervescent medicine dissolved in water. Two hours later the medicine was still beside the person untaken. This demonstrated staff were not consistently ensuring that medicines were actually taken. We raised this with the manager who agreed to look into it immediately.

Some prescription medicines contained drugs that were controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The administration of the medicine and the balance remaining was checked by two appropriately trained staff to ensure safe management of these types of medicines. We found medicines were kept securely and stored safely.

Staff with whom we spoke described a robust method of staff recruitment. Applicants were required to complete an application form supplying two references. An interview took place and staff had secured Disclosure and Barring Service (DBS) clearance before commencing employment. We looked at three staff files. Two files had the correct documentation present, however one person's files had references dated after their start date which meant the provider had not checked these references prior to commencing employment. This had the potential to put people at risk. We saw the provider had recently conducted an audit which looked at recruitment files to determine whether the correct recruitment procedure had

Is the service safe?

been followed. The audit demonstrated that further improvements were required to ensure that recruitment was done in line with the provider's policy, as a number of issues had been identified. However it was clear action had been taken following the audit which showed the provider had pro-actively begun making improvements to its recruitment procedures.

We found staffing levels were not always sufficient to ensure a consistent level of care and support was provided. The service operated two 12 hour shifts covering the day and night periods. During each shift, care was led by a senior care worker and supported by two care workers. In addition a cook was employed to deliver all aspects of food preparation and menu planning. A domestic worker carried out all cleaning duties. The staffing levels each day showed a consistent availability throughout the day yet workload was highly variable. This meant that the current allocation of staff created 'pinch points' where demand was much greater than the staffing resource available.

One staff member told us that in the morning the medication round, 'person of the day' scheme and completing care plan documentation took up lots of time and took a staff member away from care duties for a significant amount of time putting pressure on other care staff. Staff told us that in addition to caring responsibilities care workers had laundry duties; this arrangement put further pressure on staff and detracted from care workers prime responsibility to care for people. At times our observations showed people were left unsupervised indicated that staff were not consistently meeting their needs. For example, in the morning we observed that there were occasions when there was not appropriate levels of supervision of the ground floor area, with staff not visible for periods of 10-15 minutes. We observed one person was repeatedly shouting for assistance; no one came so a member of our inspection team went to find someone as they needed the toilet. In the morning, we saw staff did not have time for much interaction with people, for example a number of people fell asleep during the morning in the lounge and there was no interaction or stimulation.

One person's morning medication was left beside them for two hours and staff did not notice it had not been taken. During the lunchtime meal one person required support with the meal but the staff member providing their support had to keep leaving to attend to other things. Another person was eating their rice pudding with their fingers, and no one noticed. People told us staff were often very busy. One person said, "The staff are lovely but I don't always get a cup of tea when I ask because they might be busy you see." Another person said, "Staff listen and talk to us, but they don't answer the buzzer very quickly." A third person said, "I can't go to the toilet when I want to, I always have to wait and I can't always hold on you know." This demonstrated that there were not consistently enough staff to meet people's needs.

Staff told us that recently there had been occasions where people had required end of life care which necessitated two staff for certain elements of care; the staffing levels had not been increased to deal with this demand. There was no formal tool to assess the required staffing levels in the service. Without a structured approach to matching people's dependency to staffing requirements there remained a continuing risk to people's safety.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We looked at seven care plans. We saw risks to people were assessed on admission which helped staff to be aware of risks to people. However, these were not consistently translated into periodic risk assessments. For example, care plan documentation showed that risk assessments should be completed for skin integrity and nutrition on a monthly basis but these were not always completed, which meant risks to people may not be promptly identified.

Our inspection of the building showed the building was a safe environment in which to care for vulnerable people. Radiators were covered to protect people from burns and upper floor windows employed opening restrictors to protect people from falls from a height. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. There was sufficient communal areas and space to fulfil activities and daily living. Outside there was a spacious garden area which one person told us they, "Enjoyed spending time in." We saw a programme of refurbishment was ongoing to further improve the environment, for example a new quiet lounge had been developed. Regular checks of the building were undertaken such as fire, window restrictors, gas safety and water temperatures to help keep people safe.

Is the service safe?

The manager told us since they were recruited in September 2014; identifying and rectifying poor practice amongst staff had been one of their highest priorities. We saw evidence which confirmed this was the case; for example, disciplinary procedures had been followed where poor practice was identified to help keep people safe.

Is the service effective?

Our findings

People and their relatives spoke positively about the care received. For example one person said, "I've been here quite a while, everything's lovely. I have no concerns, I am well looked after, warm and fed and I have company," A relative told us “{the person] is very well looked after here.”

Consent was not always sought correctly, which put people at risk of harm. During our inspection of medicines we were informed that one person with dementia received their medicines covertly. Our subsequent scrutiny of the persons care plan showed a letter had been received from a GP authorising the giving of crushed tablets covertly. However we found no evidence that there had been a formal assessment of the person’s mental capacity and a best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the person knowing was in their best interests. We raised this with the manager who confirmed that no best interest meeting had been held. There was no written guidance or planning documentation to show staff how medicines would be administered without the person knowing. This meant there was a risk the person’s rights were not protected as the decision had not been made in their best interests. Once we identified this issue with the manager, we saw they took immediate steps to resolve the situation, including obtaining specialist advice from within the provider and contacting the pharmacy.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We were told by the manager that no people were subject to DoLS authorisations and no applications had been made. Staff with whom we spoke said they had not received training in the Mental Capacity Act 2005 (MCA) but had undertaken computer based learning on DoLS. Staff demonstrated a poor understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards which meant there was a risk the correct procedures would not be followed to protect people’s rights under the Act.

We looked at the care records of four people who demonstrated a significant degree of cognitive impairment. We could find no evidence of a mental capacity assessment even though some care plans stated the person was lacking capacity. We noted that the provider utilised a number of methods which may constitute a deprivation of liberty such as external and internal access control.. We judged that the provider was exercising complete and effective control over some people’s care and movements however there was no documentation in place which had highlighted these restrictions. For example, in one person’s records there was evidence staff had “caught them trying to go out of the fire door”, however there was no assessment of their capacity to make this decision for themselves. Therefore this restriction may amount to a deprivation of their liberty. The manager told us that capacity assessments had not been completed but said they would take immediate steps to assess people’s capacity and submit DoLS applications where appropriate.

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

Our discussions with staff, people using the service and observed documentation demonstrated that consent was sought and was used in the delivery of routine care. In addition we observed staff seeking consent to help people with their needs. People reported choice in the service for example one person told us how when they asked if they could move to a bigger room, this was accommodated. People also told us they were given choice over daily living such as where they wanted to spend time and what activities they wanted to be involved in. We saw that care plans recorded whether someone had made an advanced decision on receiving care and treatment.

Our observations showed people were provided with regular drinks and snacks throughout the day and given sufficient choice. People confirmed to us they were given enough to eat and drink and had a good choice. For example one person said, “We have a choice of food at mealtimes, I've never not liked anything, we get enough to eat and drink.” We saw care staff clearly and patiently explained the choice of food on offer to each person to help them understand the options available. People had the ability to request individual dishes should the planned menu not meet their needs. We saw that care plans included a nutritional profile for each person which documented food allergies, likes, dislikes and particular

Is the service effective?

dietary needs such as a gluten free diet. We spoke with the cook who demonstrated a thorough understanding of people's needs regarding nutrition, this included a good understanding of how to provide a nutritious vegetarian diet and diets to cater for people's specific allergies. We saw some people who were deemed at risk of poor nutrition were offered fortified food, for example cream in their porridge to help meet their needs.

People were weighed in line with the requirements in their care plans and we saw where weight loss was identified, this was highlighted and action taken for example liaison with GP's to ensure people's needs continued to be met. However nutritional risk assessments were not always completed on a monthly basis as required by care plans, which meant there was a risk changes in people's nutritional needs would not always be promptly identified.

Staff had access to a range of training. This included face to face training in fire and moving and handling which all staff were up-to-date with. Other training was delivered through computer based training. This included DOLS, dementia, fire, first aid, health and safety, food hygiene and infection control. However staff reported that computer based training was poor and did not always give them the skills and knowledge required. The manager also said that computer based training was not ideal and said they were keen to implement more face to face training with the aim of giving staff a better understanding of training topics. We found staff did not demonstrate a thorough understanding of safeguarding or DoLS which was delivered via the computer based system indicating the training was not fit for purpose. A health professional also raised concerns with us that some care staff did not have the required level of skills and knowledge to meet people's needs. We looked at induction records. In one staff member's file there was no evidence of any induction training, in another we found several sections of the care assistant induction were blank, for example the sections on safeguarding and whistleblowing were blank which meant staff there was no evidence staff were given the necessary training in these areas. The manager was unable to demonstrate overall compliance rates with mandatory training, therefore it as difficult to keep a track on how many staff had completed training and when further updates were required.

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

We saw the new manager had begun holding supervisions with people, these were an opportunity to discuss any improvements required to work practice and any concerns. Staff told us they felt well supported by the new manager. We saw a training needs analysis had been done with the aim of improving training provision, to meet staff's individual needs.

People reported they had access to healthcare services. For example one person told us, "Doctor and nurses come if we need them, I've no complaints" Relatives we spoke with said that they were good at assessing healthcare needs and calling doctors and good at meeting healthcare needs of their relatives. We saw evidence that people had accessed other health care providers such as audiologists, opticians, dentists, district nursing services and hospital consultants. For example, we saw the GP had been consulted where weight loss was identified. However, improvements to care plan documentation were required to ensure health professional advice , for example around pressure area care, was used to update care plans. As this was not always happening it meant there was a risk that key healthcare information was not considered in the care planning and review process.

Is the service caring?

Our findings

We used the Short Observational Framework for Inspection (SOFI) to observe interactions and activities in the service. We saw all people at the service appeared at ease and relaxed in their environment. We saw that staff responded positively to people, for example smiling and speaking to them slowly and patiently to aid understanding. We observed that staff included people in conversations about what they wanted to do and explained any activity prior to it taking place. Although we found staff mostly treated people with dignity and respect there were some aspects of care we observed that required improvement, notably at lunchtime. For example, one person was being supported with their food and the staff member broke off to attend to other matters, which meant their mealtime experience was interrupted. It was also not noticed by staff that another person was eating rice pudding with their hands and no action was taken to help support this person. One person kept complaining that their potatoes were not cooked and there was no salt or butter on them but they were ignored by a care worker. A care worker failed to notice that a person had become incontinent who they were supporting with their mobility and this had to be pointed out by a member of our inspection team. This demonstrated that the provider was not providing a consistent level of care and support. We raised these with the manager who agreed to look into these matters immediately.

People and their relatives all said staff were kind, pleasant and compassionate. For example one person said “All the staff are very nice.” Another person said "It is a nice house here, the staff are excellent, they never say no, they always say they will see what they can do, and they do come back (to you)."

Care plans recorded what people could do for themselves and identified areas where the person required support. However we found varying degrees of family involvement in the construction of the initial care plan and could find no evidence of any regular and formalised review involving anyone or their relatives. Care plans were not easy to follow and information was not provided in accessible formats to people who used the service. More could have been done to present information to people about their care in a format that they understood.

Staff were aware of people’s likes, dislikes and personal preferences in order for them to deliver appropriate care. The manager was also knowledgeable about people we asked them about. They told us that in the five weeks that they had worked at the service their main priority had been meeting and understanding people and their knowledge of people demonstrated they had done this effectively. During the inspection we saw the manager was in regular conversation with people asking how they were. However, the care preferences section of care plans were poorly completed and more could have been done to gain an insight into people’s past histories, likes and dislikes to provide personalised care. For example there was a person who spoke very little English but there was no specific information recorded on how to meet their cultural needs. We spoke with them and they told us they did not like the food on offer. No work had been undertaken to obtain their preferences, for example food that met their cultural needs. We saw they had difficulty joining in with activities due to the language barrier but staff did not make any special effort to include them.

People were well dressed for example with clothes that fitted, tidy hair and were clean which demonstrated staff took time to assist people with their personal care needs.

Health and care services are legally required to make ‘reasonable adjustments’ for people with disabilities under the Equality Act (2010) to ensure equal and fair treatment and promote independence. We saw that the provider had installed a passenger lift and a stair lift to promote a degree of independence and the ability to have an upstairs bedroom should they choose to do so.

People and their relatives reported that staff listened to them. Relatives we spoke with also told us they felt listened to and said if issues were raised they would be addressed by the service. The manager and staff told us visitors were welcome at any time. Relatives did not report any restrictions and said they could always visit and felt welcome

Is the service responsive?

Our findings

We looked at seven people's care records. The care plans comprised various sections which intended to record people's needs in a variety of areas such mobility, nutrition, pressure area care and known allergies. We saw that many of the predefined areas of need had not been completed and the required monthly reviews were also incomplete. Furthermore we noted a growing practice of recording outcomes of care in the daily record with no replication in the on-going review process. This over time had led to care plans being very difficult to navigate through and draw a conclusion as to the up-to-date needs of individuals. We spoke with the manager who shared our conclusion that care plans were currently not able to easily direct staff to deliver safe responsive care. We also found Do Not Resuscitate Forms were not easily accessible in the care file. Staff told us the form should be held on the first page of the care plan whereas in practice we had to search for it throughout the file. This meant there was a risk they could not be located promptly in an emergency situation.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Some care plans contained a good deal of information to help staff deliver appropriate care, however this was not consistently applied. As a result, we found examples of people's care plans not reflecting their current needs. For example, one person's continence assessment stated they could ask to go to the toilet. However it was clear that this was not the case from speaking to staff and looking at recent incontinence that had been recorded in the care plan. There was no updated responsive care plan which detailed the level of support that this person required. During the inspection we saw the person became incontinent and staff failed to notice. A health professional also raised concerns with us about inappropriate continence care to this person when they visited the service. The person's care plan did not contain a thorough assessment of their continence needs and strategies and interventions needed to assist this person.

Another person's care plan did not contain details of the support they required at mealtimes, only monthly evaluations which did not provide any information for staff to deliver appropriate care. On speaking with staff, this person needed assistance because they were visibly impaired; however there was no detailed plan of care to assist staff. Two people's care plans were missing a communication needs care plans. Both these people had difficulty communicating verbally. This meant there was no evidence their care needs in these areas had been assessed.

In another person's care plan the monthly planned checks of their oral health had stopped on 1st June 2014 with no updates since. This meant there was no evidence that appropriate care had been delivered. We saw that a dentist visit had been arranged for 15 May 2014 as it had been noted that their teeth were rotting. However the outcome of this visit had failed to be transferred to their personal care plan which just said should "assist to brush teeth" but no evidence of the advice from dentist had been incorporated into their care plan.

We saw people's mobility plans had not been amended to reflect people's current needs. For example, we observed that one person required assistance from two staff to be transferred from wheelchair to chair. However their mobility care plan said they were able to transfer themselves. We saw they were transferred by two staff from chair to wheelchair, but the techniques used were not wholly appropriately, the wheelchair was placed facing the chair which meant staff had to turn the person 180 degrees whilst supporting them up, to place them in the wheelchair. This meant there was an increased risk of injury. The absence of an accurate plan of care meant staff did not have proper information to follow.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The service employed an activities co-ordinator who was on long term absence. Whilst the activity coordinator was not on duty we observed appropriate arrangements were in place, with staff encouraging people to maintain interests. We also witnessed meaningful group activities being led by a staff member who had a natural aptitude and ability to communicate with elderly and vulnerable people. One person was also taken out for a walk in the woods following a request to go out. This showed staff were able to offer personalised activities to meet people's needs. People and relatives reported there was plenty for people to do and that "staff come and ask what we want to do". People reported they were encouraged to interact

Is the service responsive?

socially. A minibus was available which was used for various outings such as going to the coast. Various events were planned in the coming weeks such as carol singings and bonfire night and musical events.

People and relatives reported that they had no complaints and were happy with the care and support they received. People and their relatives we spoke with also said the manager was visible and there to respond to any issues. We asked the new manager about the complaints system. They showed us they had a system to respond to people's complaints and said they obtained people's feedback on a daily basis. However the manager was unaware of any other complaints they had been received prior to commencing employment at the service in September 2014 so was unclear of any previous learning from complaints.

Is the service well-led?

Our findings

A registered manager was not in place. The last registered manager left in August 2012. In January 2014 we took enforcement action against the provider due to their failure to have a registered manager in place. The current manager was recruited in September 2014, and they told us they would put in an application to become manager immediately. We found the lack of registered manager or stable management at the service had affected the quality of the care provision. One relative told us although they thought the quality of care was good at the service, but there had been three managers within an 18 month period and this meant there was no stability, and that every new manager had good ideas and made promises but they had left before their initiatives had come to fruition.

We found the provider had notified us about some notifiable incidents such as death notifications. However we had not been notified about a serious injury which occurred in August 2014. The provider had also failed to notify us about occurrences of abuse, namely physical aggression between people who used the service. We had not received any notifications of this type in 2014, despite us identifying various incidents in the period August 2014 - October 2014 which involved people lashing out at others. We warned the provider that we would take further action if incidents of this nature were not reported to us in the future.

We found the lack of continuity affected how the service was run and limited its ability to learn lessons from past experiences. For example, the new manager told us they had no access to any previous complaints received about the service, nor any information on past quality assurance surveys or any action plans which the service had been working to. During this inspection, we found a number of regulatory breaches. These should have been identified through a robust quality assurance system and rectified sooner through a formal service improvement plan before they presented a risk to people.

We saw some audits were done such as medication and daily checks of the building and staff files. A training audit had been conducted to improve training. However, further work was required to the quality assurance system to ensure it promptly identified and rectified all care quality issues. The manager told us they had not yet started doing the required programme of annual audits as they had not received the paperwork from head office. We saw some existing audits were not fit for purpose; for example, a nutritional audit had been done in August 2014 but this had not picked up the fact that people's risk assessments scores had not been calculated on a monthly basis. There was also no evidence that staffing levels were monitored against the dependency levels of people who lived at the service and we found staffing levels did not always meet people's needs. There were no robust audits of the quality of care people received which could have identified some of the care issues we identified. Audits had failed to identify and rectify the deficiencies in care plan documentation we found. There were no audits of dignity and respect or consent or capacity. A robust quality assurance system should have identified shortfalls in the provision before they became a risk to people.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Documentation relating to the management of the service were not always readily available. Policies and procedures were kept electronically , however there were a large number of policies and guidance documents which were not structured in an orderly way. This made it difficult for staff to be aware of the key policies and procedures they needed to be familiar with such as medication and safeguarding. We found staff were not always aware of the requirements of policies which indicated the current system of transmitting information was not fit for purpose. The manager agreed the current format was not fit for purpose and said they wanted to introduce paper copies of policies and get staff to sign to demonstrate their understanding.

People and their relatives spoke positively about the new manager at the service and said they were open and hard working. For example one person said, "The manager is nice". Relatives also said the manager was good and said they had attended a recent resident/relative meeting where they were encouraged to raise any concerns. We noted a relaxed and friendly atmosphere in the service with good interactions between staff and people.

There was a clear staffing structure in place with clear lines of communication and accountability within the staff team. Staff said they knew when and how to report any issues or concerns and they were confident management would provide any necessary advice or support. Staff spoke in a highly complementary way about the new manager. One

Is the service well-led?

member of staff said, “We have had a bad time recently with poor leadership. We are now rapidly improving but we have a long way to go.” Another member of staff said, “From the moment the new manager joined us there has been a significant improvement in staff morale. We now look for solutions rather than dwelling on problems.” Another staff member said, “Manager is very good, done so much good in the last few months. Happy to work here now, it’s improving day by day.”

From our discussions with staff and the manager it was clear that the leadership within the service was supportive. Staff spoke of a fair culture with a feeling of teamwork. One member of staff said, “There is no more an ‘us and them’ attitude between staff and the manager.” Staff told us that all changes recently instituted in the service had been done in a transparent and inclusive way. We saw the manager was involved in care delivery and knew the residents well. The manager confirmed to us that getting the staff to work as a team and improve morale had been one of their key achievements since taking up the post. It was evident that the new manager had started to make a number of other improvements since they began working at the service. Improvements had been made to the premises, liaison with relatives and providing behavioural management support around people with behaviour that challenged.

The manager had begun setting up meetings in order to seek the feedback of people who used the service and their relatives. For example a recent residents meeting took place in October which discussed future activities and any problems and concerns. A relative we spoke to said this was a positive meeting and they were impressed with the manager. Further plans were in place to set up a care staff meeting. Individual meetings and supervisions had been held with staff and there was evidence that performance issues had been raised and addressed to improve the standard of the care.

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	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 each service user was protected against the risks of receiving care or treatment that was inappropriate as a through assessments of people's needs was not always carried out. Planning and delivery of care did not always meet people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of responded appropriately to allegations of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing In order to safeguard the health, safety and welfare of service users, the registered person had not ensured that at all times there were not sufficient numbers of suitably qualified, skilled and experience staff on duty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities by receiving appropriate training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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 in relation to the care and treatment provided for them

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person was not protecting service users against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of service provision or identify , assess and manage risks to people's health, safety and welfare of service users. .

The enforcement action we took:
Warning Notice issued instructing provider to become compliant with the regulation by January 6th.