Caring Homes Healthcare Group Limited

Garth House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Garth House is a Nursing Home registered to provide nursing care and support for up to 42 people whose primary needs are nursing, elderly or living with dementia. The home is set in its own grounds and located in a residential area of Dorking. There were 33 people living in the home on the first day of our inspection and 31 people living there on the second day of our inspection.

The service did not have a registered manager in post. 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. A regional manager and clinical peripatetic manager were present on both days of the inspection. There was also a peripatetic manager present on the second day of the inspection.

When risk of harm had been identified there was lack of specific guidance for staff to follow in order to keep people safe. Risk assessments were either out of date or provided conflicting information in order to care for people safely. This was an area that had improved between the two days of the inspection but further work was needed to address this.

People that required equipment to help them move were not always safe. On the first day of the inspection hoists and wheelchairs were not in good working order and placed people at risk. New equipment had been provided by the second day of the inspection to address this.

There were not always enough staff provided to meet people's needs. People sometimes had to wait for extended periods of time for assistance. Call bells were not being answered promptly. Communal areas of the home were unattended because staff were busy elsewhere. By the second day of the inspection staffing levels had improved and people were waiting less however not all staff were aware of people's needs or how to support them. Staff recruitment processes were safe. Appropriate checks, such as a criminal records check, were carried out to help ensure only suitable staff worked in the home.

People were not always safeguarded from abuse. The provider had failed to refer incidents and accidents to the local authority for further investigation under their safeguarding procedures. Action had been taken to address this by the managers of the home between the two days of the inspection. Staff had been provided with updated training in this area and were aware of the whistle blowing policy in place. They knew who to contact should they have concerns about people's care.

The analysis of accidents and incidents was not always managed effectively. Measures were not always in place in order to minimise risk to people or to reduce their reoccurrence. Improvements had been made between the two days of the inspection but further work was needed to ensure these steps were taken to keep people safe.

There were ineffective quality assurance systems to monitor the service provision. The lack of regular auditing of risk assessments, care plans and staffing meant that any issues identified had not been acted upon in order to provide safe care and to meet peoples assessed needs. This had been recognised by the managers in the home who were

If an emergency occurred people's care would not be interrupted as there were procedures in place to manage this.

As a result of feedback given on the first day of the inspection the provider had begun to make improvements on how risk to people was managed. Some care plans had been reviewed with revised guidance for staff to follow in meeting people's needs. However not all care plans had been reviewed.

Staff did not always receive appropriate supervision. Nurses had received clinical supervision after the first day of the inspection. Some agency staff were not always aware of how the home was run or what was expected of them.

The Mental Capacity Act 2005 was not always followed and staff were initially not clear about consent and how it should be obtained. This had improved between the two days of the inspection. Appropriate applications had been made under the Deprivation of Liberty Safeguards (DoLS).

Feedback from people was that staff were caring and respected their privacy and dignity however due to the lack of staff on the first day of inspection this affected the quality of the care provided.

There was a clear complaints policy and procedure in place and people felt comfortable raising any issues or complaints with staff. There had been regular residents and relatives meetings where areas such as the use of agency staff and management arrangements had been discussed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people had not always been identified or acted upon and there was a lack of guidance for staff to follow to manage this.

There were not always enough staff available to meet people's needs and people had to wait for staff support. Appropriate checks were carried out to help ensure only suitable staff worked in the home.

People were not always protected from the risk of abuse because staff had not followed the correct procedures to report incidents to the local authority.

The environment in the home needed improvement. Some equipment that was used was unsafe.

People received their medicines when they needed them. Medicine was not always stored securely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always aware of people's needs. Agency staff did not always know how to support people appropriately.

Staff did not always receive appropriate supervision. Clinical supervision had been provided following the first day of the inspection to nursing staff.

The provider and staff had an understanding of people's rights under the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS).

People's health care needs were met.

Is the service caring?

Requires Improvement

The service not always was caring.

Staff did not always have time to spend with people as they were busy on other tasks. People's privacy was respected and staff spoke kindly to them when supporting them.

People were encouraged be involved in their care as much as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive

The providers did not always respond to people's changing needs.

Care plans were not person centred and some staff were not aware of how to respond the people's needs.

Activities were provided which people enjoyed.

There was a complaints policy in place and any complaints or concerns were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was not a registered manager at the home. Steps had been taken to address this however management changes had affected the quality of care people received.

Ineffective quality assurance checks put people at risk. Risks had not been identified and acted upon to help ensure the care provided was of good quality.

Staff felt unsupported by the lack of leadership in the home and morale had been affected.

The provider had not submitted notifications as required which was addressed by the second day of the inspection.

Garth House

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 was 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 first day of the inspection took place on the 14 March 2017. This was a focused inspection to see if the service was safe and being managed appropriately, as we had received information of concern. The second day of the inspection took place on the 31 March 2017 and was a comprehensive inspection. Both days were unannounced and undertaken by three inspectors who also had experience in adult social care.

Prior to the inspection we reviewed all the information we held about the provider. This included any information sent to us by the provider in the form of notifications. Statutory notifications are information about important events which the provider is required to send us by law.

We did not ask the provider to complete a provider Information Return (PIR) because we were responding to concerns raised at short notice. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who lived at Garth House. We used the Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. Over both days we spoke to 11 people, three relatives, and 15 members of care staff including the corporate clinical lead. We also spoke with the acting manager, regional manager and two healthcare professionals.

During both days of inspection we spent time observing the care and support provided to people and observed lunch being served. We looked at 12 people's care records which included risk assessments, MCA assessments and 14 medicine administration records. We also read other records which related to the management of the service for example training records, employment files, policies and procedures and quality auditing records.

Requires Improvement

Is the service safe?

Our findings

One person told us they felt safe living at Garth House. Another person said "I am safe here. You are not safe anywhere these days. Life is full of risks." Despite these comments people were not always kept safe because the risk of harm either had not been assessed or where a risk was identified action was not always taken to address this.

On the first day of our inspection we found, when a risk of harm had been identified, there was not always specific guidance for staff to follow to minimise the risks to people. One person was at high risk of falls and required a hoist when being moved. They did not have a moving and handling management plan in place to guide staff on how to move them safely. We saw examples when people were not moved correctly. One person's moving and handling plan had inconsistent information recorded which stated that staff should use a hoist for 'All transfers' but also stated the person could 'transfer independently'. Another person was moved by staff that used a standing frame when they required a hoist. We had to intervene to prevent this person from being moved unsafely.

Agency staff moved a person by using an under arm lift which is contrary to safe moving and handling procedures. Between the first and second day of the inspection staff had been given refresher moving and handling training and were seen moving people safely with appropriate equipment. However we saw one person was moved in a wheelchair but did not have their feet on the footplates which was unsafe and placed them at risk of injury.

Some people were at risk of developing pressure ulcers and were nursed in bed with pressure relieving mattresses in place. This was to help reduce the risk of them developing pressure ulcers. The mattresses were not always set at the correct weight to maintain pressure relief. One mattress was set at double the person's weight placing them at risk of developing pressure ulcers, and we found several repositioning charts did not have the pressure recorded to enable appropriate management of pressure area care.

People had assessments to monitor skin integrity. One person was at high risk due to them having developed pressure ulcers yet their assessment had not been reviewed for over a year. Body maps and wound management plans were in place to record and monitor the treatment of pressure ulcers. Information recorded in these plans was inconsistent and did not provide a clear audit trail of care and treatment undertaken. Wound photographs had not been updated and the frequency of dressings changed was not always competed. This meant that people were at risk of receiving inconsistent care.

On the second day of our inspection improvements had been made in the way wound care was managed. The service had implemented new wound care booklets which contained body maps, photographs, wound measurements and dressing frequency. This provided an accurate account of progress or deterioration in the wounds. However we found that some repositioning charts were still not maintained appropriately and there were some gaps in recording of position.

The risk of malnutrition was not always recognised or acted upon. During lunch on the second day of the

inspection one person was served lunch which was left on the bed table for 40 minutes before a member of staff supported them to eat by which time the food was cold and they did not want to eat. This person had lost weight over three months and was on food supplements. However we did not see this being offered to them and there was no record of supplements being given on records we saw.

People were not always kept safe because accidents and incidents were not always reviewed to minimise the risk of them happening again. A record of accidents and incidents was kept but these had not been reviewed recently to look for patterns or triggers that may suggest a person's needs had changed. There was no record of the action taken and measures put in place to prevent reoccurrence.

The failure to ensure that risks to people's safety were identified and managed meant that people were not receiving safe care. This is a breach on Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) 2014.

On the first day of our inspection people were not safe because staff did not always understand their roles with regard to safeguarding people from abuse. Two staff told us they would report anything they were unhappy about to the person in charge. Several incidents had occurred in the past six weeks, which included unexplained bruising and unwitnessed falls that had not been appropriately referred to the local authority. We asked the regional manager to notify the local authority during our inspection which they did.

On the second day of inspection improvement was seen in the way the manager recorded and acted upon incidents. They had provided the local authority safeguarding team with details of the incidents. Staff we spoke with were clear about what they should do in relation to safeguarding incidents.

Equipment was not always safe for people to use. We saw two staff trying to move a person into a wheel chair using unsafe equipment. The hoist used had been serviced recently however it had been identified that the brakes were not working which made it unsafe. We brought this to the attention of the staff who found a second hoist. However we later found staff had continued to use this hoist. We asked the person in charge to take this out of use to prevent an accident.

One person had their own wheelchair. One of the foot plates was missing and the other foot plate did not have an ankle strap, there was no lap belt to help prevent them falling from this. We pointed this out to staff and a replacement wheelchair was used. This also had a broken foot plate which had been taped up with surgical tape. This also did not have a lap belt so staff had to find another one which resulted in the person taking 45 minutes to move.

The day after our first inspection we were told both hoists were out of order and a replacement had been received from another service. On the second day of our inspection there were two working hoists in the service. New wheelchairs had been purchased to replace the broken ones.

Medicines were stored in the treatment/medication room which was too hot. The room temperature exceeded 29 degrees Celsius which was higher than recommended. The treatment room had a double lock on the door. During the inspection the nurse in charge was checking the medicines with the inspector and the door handle broke which meant they were locked in the room until staff were able to open the door.

We asked for the lock to be changed immediately to prevent this happening again. On the second day of the inspection the lock had been replaced. A portable air conditioning machine was in place in order to maintain the treatment at the correct temperature for the safe storage of medicine.

The standard of decoration, cleanliness and furnishing in people's bedrooms varied. Bedrooms and bathrooms on the top floor did not appear clean. Some waste bins had not been emptied and carpets were grubby and contained crumbs and bits of tissue. Paintwork was chipped in door frames and there were numerous marks on doors particularly where the door guards had been locked. En-suite bathrooms were cluttered and flooring and tiles needed attention. Floor boards creaked loudly, particularly on the top floor, and in places there were 'dips' in the carpet which were a potential trip hazard. One person had a pressure relieving mattress, the controls had worn off so the settings had been over written in pen. This was pointed out to the manager. The manager told us there was a corporate plan in place to address the refurbishment of the home. We asked them to send us a timescales for the planned date for this.

Failure to maintain equipment and premises is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were not always enough staff to meet people's needs. One person said "It's a matter of luck if I ring my bell for help. Sometimes they come and sometimes they don't." Another said "Sometimes we are short of staff but they always do their best." Whilst another said "Staff are nice when you can get one to help. I sometimes have to wait forever to go to the toilet." A relative said "Staff vary from day to day. Sometimes when they are short you see no one but during the week it tends to be better." A member of staff told us "It would be nice to be able to sit and talk with people as it should not be so rushed all the time."

Staffing levels were based on the dependency of people's needs and the occupancy levels in the home. There should be six care staff and two nurses employed during the morning and five care staff and two nurses in the afternoon. One staff member called in sick on the morning of the first inspection so another was found to replace them later into the shift. Staff rotas did not always reflect the amount of staff working. For example when a staff member called in sick this had not been amended on the rota. We saw one accident report which said there were four care staff on duty instead of the required six on the day of the accident. There was a 'master duty rota' which detailed that six care staff were on duty. Therefore it was difficult to gain an exact number of staff on duty at any one time.

People sometimes had to wait for assistance from staff. We heard call bells throughout the first day of the inspection which took between five to seven minutes to be answered. One person was eating their breakfast in bed and waited for an hour to be assisted by staff. Another person sleeping in bed had a cold cup of tea which was left on their table for over an hour. Staff had given them a cup of coffee which had also gone cold.

A relative could not find a member of staff to help them for over 20 minutes and we had to ask staff who were on a break to help attend to the relative's request. People were left in the communal areas of the home unattended for extended periods of time which was not safe. Another relative said they visited the home every day and said "It is not unusual to have the main lounge unattended for over an hour sometimes".

On the second day of our inspection staffing levels had improved. There were five care staff and two nurses on duty as one member of staff had called in sick that morning. The manager had called on bank staff to cover the shortfall. There was still a limited staff presence on the top floor where two people were being nursed in bed. One did not have access to their call bell which was out of their reach and were unable to summon help when they required it.

Failure to employ enough staff to meet people's needs is a breach of Regulation 18 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recruitment procedure was safe. The provider carried out appropriate checks to help ensure they only employed suitable people to work at the home. Staff files included information that showed checks had been completed such as a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

People received the medicines they required. The medicines administration record (MAR) charts were completed properly, without gaps or errors which meant people had received their medicines when they needed them. Each MAR held a photograph of the person to ensure correct identification of individuals and there was information on any allergies and how people liked to take their medicines. People had their medicines given to them in an appropriate way by staff. For example with food or after food as directed.

Medicines given on an as needed basis (PRN) and homely remedies (medicines which can be bought over the counter without a prescription) were managed in a safe and effective way and staff understood why they gave this medicine.

People would continue to receive appropriate care in the event of an emergency. There was information and guidance for staff in relation to contingency planning and we read each individual had their own personal evacuation plan (PEEP). The deputy manage told us people could go home to family or use other homes in the organisation if the home had to be evacuated for any length of time. A recent fire risk assessment had been carried out on the building and fire drills were undertaken routinely both for day staff and during the night. Training records showed staff were up to date with fire training which meant they would know what to do should the need arise.

Requires Improvement

Is the service effective?

Our findings

Due to a number of staff leaving the use of agency staff had increased and this had affected the quality of care provided as agency staff did not always know people's needs. One relative said "There are too many agency staff used here and they don't know the people".

On the first day of the inspection we saw one person would 'hit out' at times due to their disorientation. There was no management plan in place to guide staff who was unclear on how they should manage this. On the second day of our inspection one person was shouting continually during lunch. It was clearly affecting other people and upsetting them. We asked a staff member to intervene but they told us it was their first day and did not know how to. Eventually one of the management team came and removed the person from the dining room to try to relieve their distress.

On the second day of our staff were still not confident how to manage this persons needs and were not always clear what to do when their behaviour changed. There was no care plan in place to record when incidents happened and agency staff were not clear on what their needs were. One agency staff member was supporting this person in their room however were not engaging with them which led to them becoming agitated. The regional manager recognised this and went and spent time with the person and gave them a hand massage which calmed them down.

Two agency staff were working who were not familiar with the home or people's needs. One was unsure where equipment was and could not find items of bedding. They had not been given an induction and were unsure of what they should be doing. They said they felt "Lost" as they had not had an induction or been introduced to staff or people.

Failure to employ suitably skilled and experienced staff to meet people's needs is a breach of Regulation 18 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Other staff had undertaken induction and mandatory training necessary to undertake their roles however this had not always been put into practice, in particular in relation to moving and handling. All new staff undertook induction training in line with the Care certificate and were only allowed to work alone when they were assessed as competent to do so. Mandatory training included health and safety, food hygiene, fire safety, dementia awareness, oral hygiene, MCA awareness and manual handling which had been updated the previous week. One member of staff told us they were working towards their care certificate and were enjoying this.

Nursing staff told us they were provided with clinical training to include tissue viability, catheter care, venepuncture and medicine updates. They told us they had support with revalidation in order to renew their professional registration. This is a process set by the Nursing and Midwifery Council (NMC) that all qualified nursing staff have to undertake in order to be allowed to practice in the UK. The corporate clinical nurse had undertaken clinical supervision on all the nurses prior to the inspection.

Staff told us supervision was 'hit and miss'. The regional manager told us supervision had taken place and

that included group supervision however staff were not able to meet with their line manager on a one to one basis, for supervision and appraisal. Records showed staff had not received supervision regularly. Supervision gives a line manager the opportunity to check staff were transferring knowledge from their training into the way they worked. An appraisal is an opportunity for staff to discuss with their line manager their work progress, any additional training they required or concerns they had. Both of these are important to help ensure staff are working competently and appropriately and providing the best care possible for the people they support.

People gave positive feedback regarding the food provided and were happy with the quality, quantity and choice available... One person said "The food is home cooked and very tasty. " Another person said "The food is very good. I do like my meals very much." A relative said "The food seems very good here. It always smells nice." The chef provided plates of fresh fruit, hot cross buns and tea cakes throughout the day for people to snack on should they wish to. One person said "The breakfasts could be improved with more fresh fruit offered."

Despite these positive comments some people did not always have enough food and fluid to keep them healthy. On the first day of our inspection several people were being cared for in bed on the upper floors and either did not eat their lunch or were left for extended periods of time with cold food on their bed tables. They did not have staff support to help them eat and drink. On the second day of our inspection there were less people being nursed in bed as more people were eating in the dining room however some still did not get staff support when they needed.

Menus were seasonal and reviewed regularly. These were displayed on dining room tables which showed people what was on the menu that day. There was a choice of starter followed by a main course. Lunch was served in different areas in the home. Some people had their meal in the main dining room whilst others chose to eat in the lounge or smaller dining area.

People had nutritional care plans and specific dietary needs were addressed in these. If people had specific dietary requirements they were referred for appropriate professional guidance. There was also guidance for staff to follow if people required specific support when eating and drinking. For example if people needed their food to be cut up, required soft food or if they needed a cup with a lid or a straw. However we did not always see staff following this guidance which left some people unsupported at mealtimes.

Monthly weight checks were in place which enabled staff to assess and monitor if people were eating and drinking enough. On the first day of our inspection we identified several people had experienced weight loss which was recorded. This was not always acted upon. We brought this to the attention of the nurse who assured us they would take immediate action. At the second inspection people's weights had been reviewed and people who were at risk of weight loss had been placed on weekly weight monitoring. They had also been referred to the appropriate health professionals for specific guidance.

Actions were not always taken effectively where people lacked capacity to consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider was not working within the principles of the MCA. There were 12 people that had bed rails in place. Bed rails can restrict a person's movement and people, or their representatives (if legally entitled) should consent to their use. Mental Capacity Assessments had been undertaken but there was no information available around best interest decisions as why people needed these. Statements were not specific to the decision and included 'Unable to communicate X needs' and another 'Has dementia'.

Applications for DoLS authorisations had been made for the 12 people who lacked capacity to consent to the use of this equipment. Appropriate DoLS applications had also been made for people who lived at the home.

Staff's understanding of consent varied. One staff member said "I would never do anything before asking the person first." One staff was seen to move someone without consulting them while another staff member asked "Would you like to go to the dining room now for wait a little while."

People were supported to maintain good health. Care records showed people's health care needs were monitored and recorded visits made by other health care professionals. People were registered with a local GP who visited the home weekly or more frequently when required to do so. People were also visited by a dentist, optician, dietician, and other health care professionals on a regular basis. During our visit a person had a care review undertaken by the local authority, and people were visited by their GP. A person was feeling unwell and a nurse asked them if they would like to see their doctor. They said there was no need to so the nurse checked their blood pressure and temperature in order to make sure this was satisfactory. They agreed that if there was no improvement later then they would ask the doctor to visit. The person felt reassured by this.

Requires Improvement

Is the service caring?

Our findings

People's views on staff varied. One person said "Some staff are better than others; of course you have your favourites." One person said "Yes the care is good here. Another comment was "They take good care of me here." A health care professional said "The staff were caring and they try their best. They will assist me when I need this."

On the first day of our inspection we saw staff tried to spend time talking to people however there were times when they could not do this. One person was calling for help and a staff member said "I will be with you shortly." However when they finally got to attend to the person they had forgotten why they were asking for help. Another person had their legs on the floor when they should have been elevated to aid circulation. We saw a member of staff lift the person's legs and put them on the foot rests without consulting the person or speaking a word. On the second say of the inspection the situation had improved as there were more staff available to spend time with people.

At times there were positive interactions between people and staff. One person was anxious their visitor had not come to see them. A member of staff took the time to explain and reassure them about this. This was done in a caring and compassionate way and their visitor turned up after lunch.
During the morning coffee was served in the lounge. The catering person offered people a choice of drinks and biscuits. They followed this up by saying "Are you comfortable like that or would you like me to put your table up a little higher so you can manage better?" They both exchanged a smile and "Thank you."

Other times we saw staff were not engaged with people. We asked two staff working on the first floor during the second morning about the care they were undertaking for people. They were unsure of people's care needs and one staff said "I do as I am asked." There was little understanding about the person they were caring for. Communication was limited as staff were unsure to what extent people could understand. We asked if a person wore a hearing aid and the member of staff did not know.

We asked a member of staff if they could identify a particular person for us. They pointed to the person but we later discovered that they had identified the wrong person as both people had the same first name. Staff were unable to form positive relationships with people as they were task orientated and did not have the time.

People's privacy and dignity was respected. People received personal care in the privacy of their bedroom with the curtains drawn, or in bathrooms that had doors that locked. People were addressed by their preferred name and this was usually by their first name. Staff discussed anything confidential relating to a person in private so they could not be overheard by other people or visitors.

People who were able to were involved in their care as much as possible. When people were admitted to the home they had been asked about things that mattered to them. For example how they liked to spend their time, where they ate their meals and how they liked to have their personal care undertaken, what time they got up and went to bed and if they liked a newspaper. One person liked a daily shower but this did not

happen as staff did not have time to spend encouraging them when they required this. Relatives told us they were able to visit their family members at any time.

Requires Improvement

Is the service responsive?

Our findings

People did not receive care that was responsive to their needs. One person had pain in their legs on the first day of the inspection. Staff did not respond to this and it was only when the nurse was undertaking the medicine administration that they were asked if they wanted something for the pain.

People had a needs assessment undertaken before they were admitted to the home in order to ensure the service had the resources and expertise to meet their needs. These included how people needed to be moved, how they liked their personal care to be undertaken, if they had any dietary needs, how they communicated, the amount of staff required to undertake their care, and their medicine plan. However these assessments had not been reviewed and updated to reflect people's changing needs. For example when a person needed to be moved by staff rather than being mobile or when a person was nursed in bed as opposed to being able to get up.

Care plans were written on the information gathered from the needs assessment, input from the person whenever possible, and information obtained from relatives. Care plans were not personalised and focused mainly on the clinical care people needed. They lacked individuality emotional and social needs. They did not include people's past life history that would enable staff to build a picture of that person and ensure that care was delivered in a person centred way. Contradictions were seen in some people's care plans. This meant staff were not provided with the most up to date information to deliver personalised care in a responsive way to meet people's needs.

On the second day of our inspection we saw the clinical nurse had taken steps to review care plans in order to ensure the most up to date information was available. However further action was needed to ensure the required improvements were embedded and sustained.

There were no activities organised during the first day of our inspection which meant people were sitting for long periods of time unoccupied. Activities were available for people on the second day of the inspection. One to one activities took place in the morning for people who were in their rooms. This took the form of a general chat around hobbies, interests, and family. One person was talking about their Mothering Sunday cards they had received. Following this a group exercise activity took place in the lounge and people who participated enjoyed the exercises. During the afternoon a blindfold fruit-tasting quiz took place. People told us they looked forward to their activities and said "She (the activities co-ordinator) is like a breath of fresh air". One person said "I choose the activities I like and we have a lot of fun together." Another person said "I would like to get out more."

People and their relatives had been provided with a copy of the complaints procedure when they moved into the home. This was included in the welcome pack and statement of purpose. This included guidelines for on how and by when issues should be resolved. It also contained details of relevant external agencies such as the Local Government Ombudsman and the Care Quality Commission if people were not satisfied in the way their complaint was managed. There had been one complaint recorded in the complaints book since January 2017. One person told us "If I had a problem I would report it to the manager." Another person

told us "I complained about my laundry being lost once and they found this for me."

Residents and relatives meetings took place when people were encouraged to air their views and receive feedback and information about what was happening in the home. The last residents meetings took place in March when nobody had any concerns.

The last relatives meeting also took place in March. Issues of concern were the future arrangements for the management of the home which the regional manager responded to. Other concerns were about the over use of agency staff. Relatives were told about the plans in place to recruit staff.

One person had to move rooms on a temporary basis due to maintenance issues. On the first day of the inspection they told us they were unhappy about this and they missed their own room. On the second day of the inspection the situation was unchanged. They said "I keep asking when I can have my own room back but nobody seems to know. I miss my room and looking out from my bed to see the birds in the trees". This arrangement had being going on for several weeks and the management team were unable to provide an answer. The old room still had all their personal belongings including clothing, papers, family photographs and toiletries. We asked the management team to arrange for this person at to have their own possessions with them while the room issue was being resolved.

Requires Improvement

Is the service well-led?

Our findings

Prior to the inspection we had concerns raised with us about the management arrangements in the home. The previous registered manager had left in February 2017 and whilst a replacement had been recruited they had also left. The deputy manager had also resigned prior to the inspection. The home was being overseen by the provider's regional manager and clinical lead.

Some people were aware of the management changed in place. They were aware that the registered manager had left but were unaware of the various roles of the management team currently in place. One person said "I get confused with all the different faces."

On the first day of the inspection staff told us that morale had been affected by the management changes and felt unsupported as a result. One member of staff said "Morale is low at the moment and I think it is because of all the management changes. One person tells you to do something one way and someone else tells you another way. It can be quite frustrating". Another staff member said "We miss the deputy manager as they worked on the floor, coordinated everything and knew the residents. They knew everything and we could ask them anything. They made appointments and made sure people were looked after properly."

There was a lack of organisation which impacted on the care provided to people. Staff were not always aware of what was expected of them or where they would be working. On the first day of our inspection one member of staff started their shift but did not know what floor they would be working on. On the second day of the inspection one member of agency staff was asked to care for people on the top floor but had not been told about people's needs and did not know how to support them. On the first day of the inspection we found the management team did not have a comprehensive oversight of the home and there were ineffective systems in place for monitoring service delivery. Audits had not been completed around care plans, risk assessments, nutritional audits and other areas of the home. This meant that any shortfalls in people's care were not identified and action had not been taken to ensure people were receiving safe, effective and responsive care.

Quality assurance audits had been ineffective and had not identified the issues above in relation to agency staff. It also failed to recognise issues around cleanliness and décor in people's rooms. Shortfalls in records to include care plans, risk assessments recording charts, weight monitoring and MCA assessments were not identified due to the lack of effective quality monitoring.

Essential records relating to the care and treatment of people were not always accurate or up to date. Risk assessments had not been updated or implemented when risks of harm to people had been identified. Some care plans were not being kept up to date and gave conflicting information making it difficult for staff to follow. In addition the staffing levels in the home were inconsistent. There was also a lack of oversight of accidents and incidents to minimise them re-occurring. Health and safety audits had not been undertaken recently which should have identified the issues found at the inspection in relation to the equipment people used.

Records relating to the care of people and the management of the home were not always well managed and care plans were not always stored securely when not in use. People's care records were not stored always securely and were sometimes left unattended for periods of time. For example people's post was not handled well. There were unopened letters left in the diary on the nursing station desk which were over two weeks old and which had not been given to people.

On the second day of the inspection there had been improvements made in relation to this however time was needed to make improvements. The management team that was in place were clear what areas needed addressing and had started to do this. For example clinical supervision with all nursing staff had been completed and where issues had been identified staff had been provided with an improvement action plan on order to improve care practice.

Lack of robust auditing meant that effective systems and processes were not in place to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not always notified us appropriately of significant events which meant we could not check that appropriate action had been taken when incidents occurred. This is a breach of Regulation 18 of the (Registration) Regulations 2009

By the second day of our inspection the provider had appointed a peripatetic manager to oversee the home and to make the improvements needed. They had spent their first week getting to know people and staff and familiarising themselves with issues that needed to take priority. They were in the process of organising the staff rota to allocate staff to work together according to their experience and skills to improve care outcomes for people.

By the second day of the inspection work had begun to improve records relating to the care and treatment of people more improvement was required to ensure these were robust and contained all the relevant information and guidance for staff to follow in order to meet people's needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Incidents had not been reported appropriately to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always identified or acted upon which meant that people were not always receiving safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment had not always been maintained to an appropriate standard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of robust auditing meant that effective systems and processes were not in place to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff employed

Treatment of disease, disorder or injury	to meet people's needs.