Colbury Care Limited

Colbury House Nursing and Residential Home

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 31 October, 1st and 2nd November 2016 and was unannounced. Colbury House provides accommodation for persons who require nursing or personal care for up to 58 people. The home has permanent residents but also provides respite care. At the time of our inspection 44 people were living at the home.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The CQC had not received an application in respect of a registered manager.

Before the inspection, we asked 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. The provider did not return a PIR and a rating's limiter was applied to the "well led" section of this report which meant they could not achieve a 'good' rating in this domain.

People's personal emergency evacuation plans and the testing of fire alarm systems were not up to date and we could not be sure that in the event of a fire people would be safe.

Medicines were not stored and administered safely. Medicine administration records were not always completed. Temperatures of refrigerators used to store some medicines were not always recorded.

Staff did not receive regular supervision or appraisals which would have provided them with appropriate support to carry out their roles.

Not all staff had completed training in areas that reflected their job role.

Where people lacked the mental capacity to make decisions the home did not always follow the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

Some risk assessments and care plans were not always person centred and did not ensure that peoples care and treatment was appropriate, met their needs or reflected their preferences.

There were sufficient numbers staff deployed to meet people's needs. Staff were not hurried or rushed and when people requested care or support, this was delivered quickly. The provider operated safe and effective recruitment procedures.

Individual care records were stored electronically and each member of staff carried a personal data terminal to access and update records accordingly.

The provider had systems in place to respond and manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies.

People who were able to talk with us said that they felt safe in the home and if they had any concerns they were confident these would be quickly addressed by the staff or manager.

People were supported with health care appointments and visits from health care professionals.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed.

People knew who to talk to if they had a complaint. Complaints were passed on to the manager and recorded to make sure prompt action was taken and lessons were learned which led to improvement in the service.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People's personal emergency evacuation plans were not up to date. Fire alarms had not been tested regularly.

Medicines were not always well managed. People were not always receiving their medicines safely, accurately, and in accordance with the prescriber's instructions. Medicines were not always stored safely.

People were protected against abuse because staff understood their responsibility to safeguard people and the action to take if they were concerned about a person's safety.

Is the service effective?

Requires Improvement

The service was not always effective. Training and staff supervision processes had not been fully effective. Staff did not have all of the skills knowledge and support required to help them to carry out their roles and responsibilities in respect of the people they cared for.

Not all staff had an understanding of and acted in line with the principles of the Mental Capacity Act 2005. We could not be sure that people's rights were protected in relation to making decisions about their care.

People had access to and were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks.

Is the service caring?

Good

The service was caring. People were comfortable and relaxed in the company of the staff supporting them.

Staff treated people with dignity, respect and kindness. They knew people's needs, likes, interests and preferences.

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

Is the service responsive?

Requires Improvement

The service was not always responsive. The provider did not always maintain accurate records. Some care plans did not always appropriately reflect people's assessed needs, or preferences.

The registered provider had a procedure to receive and respond to complaints. People knew how they could complain about the service if they needed to.

People and relatives told us that the service they received was flexible and based on the care and support they wanted.

Is the service well-led?

Requires Improvement

The service was not always well led. The home did not have a registered manager in place. We took this into account when we made the judgements in this report and applied a limiter to the rating of this section.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). The provider did not return a PIR and we took this into account when we made the judgements in this report and applied a limiter to the rating of this section.

Accidents and incidents were investigated to make sure that causes were identified and action was taken to minimise the risk of reoccurrence.

Colbury House Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 31 October, 1st and 2nd November 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience who has personal experience of using or caring for someone who uses this type of care service, in this case older people and people living with dementia. We were also accompanied by a specialist nurse with experience in providing nursing care.

Before our inspection we contacted one health and social care professional in relation to the care provided at Colbury House. During our inspection we spoke with eight members of staff including the manager, 14 people living at the home, five relatives and one GP. Following our inspection we contacted two health and social care professionals to seek their views and observations of the delivery of care at Colbury House.

We looked at the provider's records. These included six staff files, a sample of audits, satisfaction surveys, staff attendance rosters, and policies and procedures.

We pathway tracked six care plans for people using the service. This is when we follow a person's route through the service and get their views on the care they received. This allows us to capture information about a sample of people receiving care or treatment.

We asked the provider to complete a Provider Information Return (PIR) before our inspection however the provider failed to do this. 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.

Some people were not able to verbally communicate their views with us or answer our direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The current manager had previously left the service in December 2014. During that time the provider had employed two further managers. The current manager returned to the service as an external quality improvement consultant in April 2016 and took over the role of manager on 1 September 2016.

We last inspected the home in November 2014 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

The service had taken appropriate steps to protect people from the risk of abuse. Staff were aware of their responsibilities in relation to safeguarding. They were able to describe the different types of abuse and what might indicate that abuse was taking place. Staff told us there were safeguarding policies and procedures in place, which provided them with guidance on the actions to take if they identified any abuse. They told us the process that they would follow for reporting any concerns and the outside agencies they could contact if they needed to. One person said, "Yes I do feel safe here because the staff are always on the lookout for you". Another person told us, "Yes I do feel quite safe here. I've never had any problems with the carers. They treat us all well". Although people told us they felt safe we found a number of concerns in relation to peoples safety at the home.

The personal emergency evacuation plans (PEEP) folder located at the entrance to the home did not contain evacuation details for six people who had moved into the service between 11 July 2016 and 31 October 2016. The folder also contained details of three people who had moved from the service between 30 July 2016 and 24 October 2016. The provider did not have up to date information to support people in the event of an emergency or fire which could impact on the person's safety. Fire alarm testing had not been carried out since June 2016. This meant the provider could not be sure that equipment had been working effectively during this time to keep people safe. The provider had failed to do all that was reasonably practicable to mitigate risks. This was a breach of Regulation 12 (2) (i) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People's medicines were not managed safely. We looked at the medicine administration records (MAR) for seven people and found that between 17 and 28 October 2016 there were 20 occasions when people should have been given their medicine or prescribed skin care cream but the MAR did not evidence that medicines had been administered or declined. We also looked at creams and ointments for a further seven people which were kept in their rooms. We found that no opening date had been recorded and that some creams were not labelled indicating who the cream was for. We also found some creams in people's rooms that contained labels indicating the cream was for another person. Medicines that were required to be kept cool were stored in an appropriate locked refrigerator however temperatures were not consistently monitored and recorded. For example, between 2 and 31 October 2016 recordings had not been taken on nine occasions. The provider could therefore not be sure that medicines were stored safely or that people had received their medicines safely, accurately, and in accordance with the prescribers instructions and were not placed at risk. This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Safe care and treatment.

We asked staff about whistleblowing. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. Staff said they would feel confident raising any concerns with the registered manager. They also said they would feel comfortable raising concerns with outside agencies such as the Care Quality Commission (CQC), if they felt their concerns had been ignored. Comments from staff included, "I would report any issue that I was concerned about, no matter how small." And "I know how to report safeguarding and am confident to do so".

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions. Checks to confirm qualified nursing staff were correctly registered with the Nursing and Midwifery Council (NMC) were also held on file. All nurses and midwives who practice in the UK must be on the NMC register.

There were enough skilled staff deployed to support people and meet their needs. During the day we observed staff providing care and one-to-one support at different times. Staff were not rushed when providing personal care and people's care needs and their planned daily activities were attended to in a timely manner. Staffing levels were kept under review and adjusted based on people's changing needs. Staff told us there were enough of them to meet people's needs. Staff provided care in a timely manner to people throughout our inspection.

Staff responded to call bells quickly. People said call bells were usually answered promptly and staff responded quickly when they rang for help. One person said, "I've only use the call bell once, it did take a few minutes to be answered but I believe they were busy at the time". Another person told us, "Usually when I press my buzzer they are there in seconds. Very rarely have I had to wait longer than two minutes". People who were unable to use this system were checked by staff at regular intervals to ensure their safety but also monitor their needs.

Requires Improvement

Is the service effective?

Our findings

Some staff had not received all of the training relevant to their role. Some of the people being supported by the service were living with dementia and were also at risk of developing pressure sores however not all staff had received training in these specialisms. Training in these areas would give staff a greater understanding and would promote good practice to enable and support people to live their lives fully. A number of staff told us that they felt additional training in dementia awareness and the care and treatment of people at risk of pressure sores would be helpful and would assist them to understand in more detail how people live with dementia.

Staff had not received regular supervision or appraisals. Supervision and appraisals are important processes which help to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The provider had identified this in their quality improvement report plan dated 20 May 2016 but it had not been implemented by the previous manager. One member of staff told us, "Supervisions, what's one of those? I can't remember the last time I had one. The new manager has put a list up on the wall telling us who should be doing them but nothing's happened so far". Another member of staff said, "I think I had one about a year ago but they just stopped". A further member of staff said, "It would be nice to have one and know how I am performing but it doesn't happen". One nurse told us, "I don't know when my revalidation is due and I have had no discussions with the management regarding my revalidation as yet". Another nurse told us, "I talked with my manager about my revalidation and I also supported him regarding the revalidation process". Revalidation is the process all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC).The manager told us, "I know they (supervisions) haven't happened and I am working to address this but my door is always open if staff want to talk to me". Staff did not receive appropriate support or training to enable them to carry out the duties they were employed to do. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

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's mental capacity had not always been assessed and taken into consideration when planning their care needs. For example, handover notes and a medication care plan in respect of one person indicated that they received their medication covertly. The manager and two staff members confirmed that the person was having medication administered covertly. The manager was unable to provide any evidence of any GP, Pharmacist family or external health care professional's involvement in this decision and no record of a mental capacity assessment or best interest decision was in the care plan. One member of staff told us that the person did have a mental capacity assessment for covert medication signed by a GP but the form went missing when the person was admitted to hospital. The MCA contains five key principles that must be followed when assessing people's capacity to make decisions. Although training records indicated that 70%

of staff had received training in this area staff we spoke with were not knowledgeable about the principles and codes of conduct associated with the MCA 2005 and were unable to apply these appropriately for the people they cared for. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the time of our inspection eight people living at the home were subject to a DoLS which had been authorised by the supervisory body (local authority).The home was complying with the conditions applied to the authorisation. The home had submitted a number of further applications which had yet to be authorised by the local authority. The manager knew when an application should be made and how to submit one. They were aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

People were supported with their healthcare needs, including receiving attention from GPs and routine healthcare checks. One person told us, "The GP visits every week to make sure we are all fit and well but if I feel unwell at any time I can request a visit and he comes to see me. Another person said, "If I needed to see someone like the doctor or optician I'd tell the staff and they'd make arrangements for me. The doctor does come here regularly on Thursday so it's easy to see him". Another person told us, "The staff do arrange for us to see anyone we need to, they're quite happy to do that for us". Care records demonstrated people had visits from health care professionals, such as doctors, chiropodists and opticians. Peoples health care needs were considered within the care planning process. Assessments had been completed on people's physical health, medical histories and psychological wellbeing. Arrangements were in place for peoples healthcare needs to be monitored through a regular review process.

People told us the food was very good and drinks, snacks and fruit were available throughout the day and night if people required it. One person told us, "I do like the food yes. I do tuck in quite well. There's plenty of tea, coffee, squash water and you do get refreshments as well like biscuits, cake, and fruit when you want, anytime you want actually". People were provided with choice about what they wanted to eat and told us the food was of good quality and well balanced. The chef followed a menu that took account of people's preferences, dietary requirements and allergies. The chef kept records of refrigerator and freezer temperatures as well as core cooking temperatures. The chef told us, "I have all the training the staff have in respect of dementia awareness. It helps me to understand people living here especially around their dietary requirements. It's important to me and for the people I cook for to fully understand what they like and dislike".

We observed the lunchtime meal and saw that people received individual support in a discreet and patient manner. Specialised equipment was available to enable people to eat as independently as possible. For example, adaptive cutlery and plate guards. People who required support to eat received this in a kind and patient way. One person said, "The food is good, but sometimes I don't always want what they cook so I speak to the chef and she cooks me something different". Another told us, "The food is very nice. I get enough and can have more if I want it" and "I get help with eating". Other comments included, "I get enough to drink and I ask for drinks if I am thirsty". People's relatives were also happy to tell us about the quality of the food. One relative told us, "She likes the food, lovely meals". Another relative said, "My dad does like the food. He eats well every day and can have refreshments and snacks in between if he wants them. I get fed and watered as well when I visit, they always offer me something to eat or drink".

Good

Is the service caring?

Our findings

People told us they were happy at the home and said staff treated them with kindness and were caring. One person told us, I'm very happy here, they [staff] look after me very well". Another person said, "Care staff are lovely, I am happy here". A further person added, "I think the staff here are all very satisfactory. I am happy with the quality of care that I get". One relative told us, "Its ok here. My relative has settled well since coming here. He is a different person". Another relative said, "Its ok here. The staff are all very nice and pleasant and look after my relative very well". A third relative told us, "The staff are absolutely brilliant, all of them. The place [person] was in before wasn't that nice. It was a dementia home and the staff there weren't very caring as far as I was concerned. [Person] wasn't happy there. Here, it's totally different, chalk and cheese. It's good". A GP told us, "The service is on the way up. It has had a bit of a bad 18 months but I visit at least once a week and I can honestly say I think the care is very good and the service is going in the right direction. There have been a few issues around the new care recording system but they are getting there. The home would benefit from having a clinical lead in post, working alongside the manager for supporting the staff and day to day clinical issues". A health and social care professional told us, "Our client has received a review as their placement was originally temporary but is now permanent. The review was positive and client and relatives stated they were very satisfied with the care given by Colbury House".

People felt supported by staff who treated them with dignity and respect. When we asked people if staff treated them with dignity and respect they told us, "Yes they do". One person told us, "They are very good at that. They always make sure they cover me up when they wash or bath me". One staff member told us how they ensured people's dignity was respected. They said, "I get down to their level when I am talking to people. I shut curtains and doors to give people respect". Staff knocked on people's doors and waited for a response before they entered. We also observed staff talking to people in a calm and respectful manner.

People's care needs, choices and preferences were recorded and written in a person centred way. Information within care plans reflected what was important to the person now, and in the future. For example, one person care plan indicated how they did not wish to be admitted to hospital if they became ill. Another care plan indicated a persons preference to 'lay in' on a Sunday morning and have breakfast in their room. Staff were knowledgeable about the people they supported and were able to tell us about people's individual needs, preferences and interests. Their comments corresponded with what we saw in the care plans. Care plans gave detailed descriptions of their individual needs and how support was to be provided. There had been input from families, historical information, and contributions of the staff team who knew them well with the involvement of people themselves. People were supported to maintain relationships with their family and friends. People could receive visits from family and friends when they wanted. One person told us, "My son cant always get in to see me because of work but I can use the telephone to call him when I want to". Details of important people in each individual's life were recorded. A relative confirmed they were kept up to date and they were always welcomed in the home when they visited.

People felt able to make decisions and choices about their care and support. We asked people if they had choice and felt able to choose the care they received. They told us, "They are very good here, they do what I want", "Yes the care is what I want. I like to shower every day and that is what I get" and "I like my hands

massaged it is very therapeutic for me. Staff do this for me". People's care plans had details about their likes and dislikes. For example, what foods they liked. One person told us "I don't like fish". This was confirmed in their care plan. Other examples were people's favourite music and TV programmes, people's chosen bedtime routine and the time they liked to get up.

Staff cared for people in a relaxed, warm and friendly manner. We saw that non care staff who worked in the home such as kitchen and maintenance staff took time to sit with people and chat. Staff sat talking with people and engaged in lively conversations about their families, social events and sharing memories. There was a lot of laughter and we noted that staff took every opportunity to engage with as many people as possible. For example, by bending down to ask if a person would like more tea, by touching a person's hand to ask if they were ok, and by frequently popping in and out of bedrooms to check on people.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen. Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. Staff promoted independence and encouraged people to do as much as possible for themselves. A relative said: "I know mum can't do much for herself anymore but it is good to see the staff trying to get her up on her feet and walking around a bit".

Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's likes, dislikes and preferences about how their care was to be provided. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about the person and their individual needs.

People were involved in their day to day care. People's relatives were invited to participate each time a review of people's care was planned. A relative told us, "We are pretty involved so we get plenty of notice if anything is going to change". People's wishes and decisions they had made about their end of life care were recorded in their care plans when they came into the service. When people had expressed their wish regarding resuscitation this was clearly indicated in their care plan and the staff were aware of these wishes.

Requires Improvement

Is the service responsive?

Our findings

Most care plans were person centred and contained guidance about people's personal preferences for how they liked to be supported. People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. However care plans had not always been updated to reflect any changes to ensure continuity of their care and support.

Care plans did not always appropriately reflect people's assessed needs or preferences. One person was seen to be eating biscuits although their nutritional care plan stated they were to have a pureed diet and normal fluids. The care plan did not contain details of the person's ability to eat or drink or if support was required. The persons 'Eating and Drinking' risk assessment stated they could eat anything they wanted and had no swallowing difficulties. We brought this to the attention of a nurse who told us, "The reason the person is on a pureed diet is because he suffers from sore gums", however this was not referenced in the persons care plan. Another person's risk assessment stated, "High risk of falls. Mobility with a walking frame with two staff to support", but did not contain any evidence or guidance on reducing the risk. Their mobility care plan stated, "[Person] is able to weight bear but unable to walk. [Person] needs a stand aid for all transfers". Their continence care plan stated, "Now hoisted as they are not able to get out of bed". This was a contradiction of their mobility care plan and did not reflect their current needs.

Daily records were not always accurate. For example, at lunch time we observed one person living with dementia refuse to take any food or fluids despite the encouragement of three members of staff. After lunch their food and fluid chart and recorded that they had eaten lunch that day. Inconsistencies in peoples care plans meant that the provider was unable to adequately assess and mitigate risk to people and ensure their safety. We brought this to the attention of the manager who told us, "We are transferring all our care plans onto a more robust user friendly system. Going forward every identified and assessed risk will automatically generate a care plan specific to the person with guidance on how to manage and minimise the risk". Whilst the manager had plans in place to improve care planning the concerns we identified constituted a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

People and relatives told us the service was responsive to their needs." One person told us, "Nothing is too much trouble. I only have to ask and they [staff] oblige". A relative told us, "I've been really pleased with my relative's decision to move here. The home is really good. They came for respite care but decided to stay". Another relative told us, "The home responds well to [person] needs. I did worry at first when they came to live here about how it would all work out but the home has been very good, I can't fault them". One health and social care professional told us, "The home has a process in place to ensure that when a GP visits and declines to write in the notes, the nurse captures the comments/actions and the GP signs to agree". Another health and social care professional told us, "Significant improvement has been reported in documentation and care delivery. The service was making good progress. The placement for our client was definitely meeting their needs. A very positive three month review.

People and relatives told us that the service they received was flexible and based on the care and support

they wanted. One relative said: "I visit regularly and what you see today is normal. They haven't put on a show because you are here. They look after our relative very well and they do everything they need to do to make sure he is looked after well".

We received mixed feedback regarding the activities at Colbury House. One person said, "I think activities could be a lot better, there's not a lot to do at all". Another person told us, "Yes I take part in the activities where I can as I think they're quite good actually. I enjoy the games and activities both morning and afternoon. The activities co-ordinator does come around & ask us what we want, what we would we be interested in and he does his best for us". The activities co-ordinator told us they planned activities in advance however as people's needs changed there was a need for flexibility and activities changed accordingly. Activities included, art and craft, skittles, board games, pamper sessions, exercise, and music and movement. A relative told us, "Before [person] came in here they were very withdrawn, didn't mix and never smiled. They have really come out of their shell here and I am sure they look forward to these daily get-togethers. You can see it in their face".

People were able to express their individuality. Staff acknowledged people by name as they walked past them in the lounges and corridors. People were responsive to staff and were eager to talk to them. People's room's reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their own home and people were able to choose furnishings and bedding.

The provider kept a complaints and compliments record. People and relatives told us they knew how and who to raise a concern or complaint with. The complaints procedure gave people timescales for action and who in the organisation to contact. People told us that if they were unhappy they would not hesitate in speaking with the manager or staff. They told us they were listened to and that they felt confident in raising any concerns with the staff. Complaints had been appropriately investigated and responded to by the manager. Relatives and staff were familiar with the provider's complaints procedure which was displayed in the home and they all said they would speak to the manager directly if the needed to raise a concern.

Requires Improvement

Is the service well-led?

Our findings

The service had been without a registered manager since December 2014. During that time the service had employed two people on separate occasions as managers but neither had completed the process to become registered managers with the Care Quality Commission (CQC) in respect of this location. The current manager had been in post since 1 September 2016 but had not yet submitted an application to become the registered manager. Until services have a registered manager application accepted by the CQC we are only able to judge that the leadership of the service requires improvement. However, people and staff spoke positively about the manager and their leadership. One member of staff said: "He (manager) has been under a lot of pressure to put things right. He came back earlier this year to try and sort the mess out. It's a lot better now than it was". One person told us, "Yes, I do feel this place is quite well managed. The staff do quite well so I think they're being led well by the management". A relative told us, "The manager is very open and approachable. He keeps us informed about our relative if things are not right so we are very happy".

On the 11 July 2016 we asked 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. The provider did not return a PIR by its requested date of 12 August 2016 and we took this into account when we made the judgements in this report. As the provider had failed to submit a PIR a ratings limiter was applied to this section of this report and we could only rate it as 'requires improvement'.

The manager had been previously engaged by the provider as compliance manager between April and September 2016 and had produced a quality improvement plan on 20 May 2016 identifying areas that needed improving and had set action plans with timescales to improve the service. For example, The introduction of a new electronic care plan system and key worker system allocating a named nurse supported by care staff for people living at the home. Other areas included a two week induction programme for new staff and an improved activities programme for people living at the home. These improvements had been made or were ongoing however some of the action points raised had not yet been completed. For example, staff supervision, annual staff appraisal and staff training needs.

There were systems in place to review the quality of service in the home. Monthly and weekly audits were carried out to monitor areas such as health and safety, care plans, accidents and incidents, and medication however the provider had failed to identify the areas of concern we had found and reported in the Safe and Effective parts of this report. The manager told us that he had identified a need for more support from the provider through visits and audits and had requested this in October 2016. The provider's operations team last visited the service in April 2016 and the manager told the provider that without operational support and guidance the home was at risk of falling short of the required standard. In the interim the manager had contacted a manager from another home run by the provider and requested additional support from them.

Unannounced night visits by the manager were undertaken. The last night visit took place on 15 June 2016 at 3am. This looked at the security of the home, cleanliness, hourly checks maintained and documented and staff being in their allocated work areas. The night visit report stated, 'On the whole this was an adequate

night inspection. Staff were allocated around the building as detailed'. One care assistant taking their break however had left the building but had not told he nurse in charge they were going outside. A directive had since been issued to all the staff by the manager emphasising the importance of their own personal safety and that of people living at the home with regard to the safety and security of the home.

Accidents and incidents were investigated to make sure that causes were identified and action was taken to minimise the risk of reoccurrence. Records showed that appropriate and timely action had been taken to protect people. The manager had investigated incidents and concerns raised by the local authority and had responded in a timely way. We received mixed feedback from three health and social care professionals in relation to the leadership of the service. One health and social care professional told us, "The communication between us and the home has not always been good and they have been rather slow in the past at responding to requests for information, however over the past six to eight months this has got significantly better. Another health and social care professional told us "I have not worked with the current manager for long however, trying to get assurance from the manager can be difficult".

The home did not hold formal residents / relatives meeting. The manager told us that it was difficult to hold meaningful meetings due to relative's availability and the health conditions of people living at the home. To address this the manager made himself available on one morning each week for a 'surgery'. This was to provide people and relatives with the opportunity to see him and discuss any issues. The manager told us, "It's a facility that is in place for people to come and talk and raise any concerns they may have, however I operate an open door policy and am accessible at any time. Relatives do use it regularly on arrival at the home. They often come in for a chat and to see how their loved ones are". One relative told us, "I know I can speak to the manager whenever I want and that works for me very well".

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the home and relatives. The feedback received from the last survey carried out in June 2016 indicated that most people were very satisfied with the service being provided. Comments included, "I am very pleased with the home they have looked after my uncle well", "Overall we are satisfied with his care. We have no complaints" and "Staff have always been very pleasant to deal with and put our minds at rest that [person] is well cared for. Thank you".

Staff told us communication within the team was better now than it had been during the past two years and they worked well together. Staff told us the morale was getting better and that they were kept informed about matters that affected the service. Staff told us that team meetings had not taken place regularly in the past but had recently been reintroduced by the manager. Staff told us there had been one team meeting recently, in September 2016 and told us that suggestions were warmly welcomed and used to assist them to constantly review and improve the service. Staff told us they felt comfortable raising concerns with the manager and found them to be responsive in dealing with any concerns raised.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that they were able to respond to and manage major incidents and emergency situations. The provider had not ensured medicines were stored, administered or recorded accurately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always maintain an accurate, complete and contemporaneous record in respect of some service users, including a record of care and treat treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive such appropriate support, training, supervision or appraisal as is

Treatment of disease, disorder or injury

necessary to enable them to carry out the duties they are employed to perform.