Oakleigh Healthcare (Dudley) Limited

Oakleigh Lodge

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

Overall summary

The inspection took place over two days on 10 and 11 February 2015. The inspection was unannounced. Oakleigh Lodge provides residential and respite care and support for up to 19 people who have a learning disability, mental health condition or brain injury. Thirteen people were using the service at the time of our inspection, nine people lived in the main house and three people were accommodated in three of the four adjoining flats.

A registered manager was in post but absent at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. In the registered manager's absence the home was being managed by the deputy manager, who was supported by the provider, an external consultant and the provider's personal assistant.

Summary of findings

At the last inspection on 22 April 2014 the provider was not meeting regulations in relation to assessing and planning care for people, ensuring risks to people were identified and managed, monitoring the quality of the service and obtaining consent from people and acting in accordance with the law in respect of deprivation of liberty. Following that inspection the provider sent us an action plan telling us how they intended to make improvements. During this inspection we looked to see if improvements had been made.

We saw the provider had made improvements in relation to assessing people's needs which included referrals to health professionals such as the speech and language therapist. Preventative action to keep people in good health was known by staff but further improvement was needed to check that staff were consistently delivering the preventative support people needed when for example supporting people with their meals.

We found that some people's safety was compromised because the management of risks to people was not consistent. Safeguards in place were not followed which potentially left a person at risk of harm. People's medicines were not checked sufficiently to ensure they were safe to use.

People's care needs were met by sufficient numbers of staff who knew how people liked to be supported. Staff had access to a range of training but some specialist training relevant to the care of people with complex needs was needed to meet people's needs effectively.

We saw the provider had made some improvement since our last inspection in relation to meeting the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff had received training, demonstrated an understanding of lawful and unlawful restraint and had a working knowledge of the MCA and DoLS. However further consideration of people's capacity was needed where people were not safe to leave the home independently.

The provider had improved the recruitment systems to ensure checks were carried on prospective staff before they worked in the home.

People said staff were caring and we saw staff treated people kindly. On occasion staff did not promote people's dignity. People who lived at the home and their relatives were consistently positive about the caring attitude of the staff. People were supported to do activities that they enjoyed and further opportunities were being planned.

There had been an improvement since the last inspection in terms of monitoring the quality of the service because the provider had obtained the services of an external consultant to assist with this. The provider had begun to identify aspects of the care delivery that could be improved and had taken some immediate action to address concerns we raised with him. However the systems needed further strengthening to ensure a more proactive approach to enable the provider to identify what needed to be done to ensure the risks to people's health and safety were identified and managed. There had been no improvement in relation to maintaining records related to people's care needs and this had resulted in omissions in some people's care. The provider acknowledged these shortfalls.

The action we told the provider to take can be seen at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

All staff knew to report abuse but suspicion of potential abuse or harm had not been consistently recognised or reported in a timely manner.

Although people told us they felt safe, we found this service was not providing consistently safe care because there was a lack of proper assessment and management of the risks to people's safety and welfare.

People's medicines had not been administered, stored and disposed of safely.

Requires Improvement

Is the service effective?
The service was not always effective.

People and their relatives said that they felt well cared for. Staff required additional specialist training to support them in meeting people's complex needs.

The key requirements of the Mental Capacity Act 2005 and Deprivation Of Liberty safeguards were not fully considered alongside people's care needs.

There was an inconsistent approach to maintaining people's health which potentially left a person at risk of harm.

Requires Improvement

Is the service caring?
The service was not always caring.

People told us staff were caring and listened to them.

People were supported by staff who understood their communication needs and there was a positive rapport between people and staff.

Staff did not always apply the principles of respect and dignity to their practice.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

People had not been supported to have current care plans that reflected how they would like to receive their care.

People did not have access to a complaint procedure in a format suited to their needs.

People had access to activities they enjoyed.

Requires Improvement

Is the service well-led?
The service was not well led.

Requires Improvement

Summary of findings

The management of the home was not effective in ensuring people always received the care and support they needed.

The systems in place to check on the quality and safety of the service needed strengthening.

Oakleigh Lodge

Detailed findings

Background to this inspection

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

The inspection took place over two days on 10 and 11 February 2015. The inspection was unannounced. The inspection team comprised of two inspectors and a pharmacy inspector.

We looked at the information we already had about this provider. This included notification's received. A notification is information about important events which the provider is required to send us by law, and included information about accidents and safeguarding alerts. We also reviewed information shared with us in the form of complaints, whistle blower alerts and information from the local authority.

We spoke with eight people who lived at the home, and four relatives. We observed the delivery of care to some people who were unable to tell us their views. We also spoke with a health care professional and three social care professionals. We spoke with eight members of staff; the deputy manager, four care staff, one senior care, a cook, and administrative staff. We also spoke with the provider and with the consultant who had recently been contracted by the provider to help make improvements at the home.

Our pharmacist inspector looked at the way medicines were being administered and managed for 11 people. We looked at four people's care records, records for falls, accidents, incidents and complaints. We looked at staff rotas, recruitment checks and training. We viewed staff and resident meeting minutes, quality assurance records and the provider shared with us two whistle blower alerts raised on the day of inspection.

Requires Improvement

Is the service safe?

Our findings

We were made aware that the management of people's medicines had been identified as potentially unsafe. We found that where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary safeguards were in place to ensure that these medicines were prepared and administered safely. We were particularly concerned that this complex procedure was being carried out by staff who had not received any formal training to carry out this procedure safely.

We looked at the medicine administration records for people and found the records were not sufficiently maintained. There was no record of the receipt of medicines and staff initials were missing from the administration record so we were unable to establish if the medicines had been administered. Inconsistencies were apparent between the medicines signed as given and the entries in the Controlled Drugs register which left it unclear as to whether people had their medicines as they were prescribed. Staff acknowledged the recording errors and were very keen to improve on their record keeping.

The local authority made us aware of concerns related to the safe recruitment of staff. We spoke with the provider who acknowledged that two new staff had not been fully checked. He advised us this had been an isolated incident and we saw he had strengthened the recruitment processes so that all staff had the required Disclosure and Barring Service check (DBS) carried out before they worked at the home.

Those people who were able to tell us confirmed that they did feel safe living in the home. Relatives we spoke with did not raise any concerns about people's safety. One relative told us, "[Persons' name] feels secure and safe, our experiences have been positive". Another relative said, "[Persons' name] is very relaxed and happy there; asks to go back when out with us. We are very happy [person's name] has settled and we would know if they were unhappy". A relative we spoke with was happy that their family member was safe and was able to give us an example of how the staff along with the social worker, had acted quickly following an accident and put appropriate equipment in place to reduce the risk of harm from falling.

Staff we spoke with were aware of what constituted abuse and the signs that may indicate that a person had been abused. Staff we spoke with knew how to report any allegation or suspicion of abuse. However staff described a culture in the home that had not given them confidence to report their concerns. One member of staff told us, "I would report abuse. There were areas of practice I didn't always think were right. I didn't have confidence in the manager that if I reported anything internally it would be listened to". We were concerned that staff stated they had not been confident to raise concerns. Staff we spoke with told us things had improved recently.

Staff we spoke with told us they were aware of whistle blower procedures and one staff member said, "The procedures are displayed for us to use and I know some staff have used them recently". We saw that staff were utilising whistle blower procedures to raise concerns although not always in a timely fashion which leaves people at risk of potential harm. At the time of our inspection some incidents were under investigation by the local authority and we saw the provider had taken interim action to protect people.

Risks to people who used the service had been assessed and risk management plans were in place for people who had fragile skin, were at risk of falling or choking or required the use of equipment such as a hoist. Some people told us they lived in the adjoining flats and were supported to go out independently, shop and cook. Staff told us that they had observed some people were not safe and that some action had been taken to improve their safety and increase their supervision. Whilst we saw that risks had been assessed further improvement was needed to ensure preventative plans were appropriate for people's needs. Where people needed support to manage their behaviour there was a lack of guidance to ensure staff supported the person appropriately, and understood how to anticipate, identify and manage risks which could potentially compromise the person's safety. We saw for example a person had sustained an injury but this had not been identified, recorded or communicated. This meant no review of the incident had taken place to identify if the incident required reporting to external agencies under safeguarding or whether staff had considered seeking professional advice to manage the person's behaviour. This incident was subsequently reported by the home to the local authority.

Requires Improvement

Is the service safe?

Some people told us that there was enough staff to support them during their daily activities. We saw that staff were present in the main communal areas to support people and to take them out on their activities. A staff member told us, “There are enough staff we can generally cover all the commitments people have”. A person living there told us, “Sometimes I could do with more help”. A relative told us, “There always appears to be sufficient staff, I’ve never noticed a problem”. We saw the complexity of different people’s conditions and the additional flats accommodating people meant that there were more demands on staff to meet people’s needs. There were some examples that indicated some people may not have had the support they needed. These were shared with the provider but we are unable to report on these in order to protect people’s identity.

The provider told us they were looking at the dependency levels of people, including those people who required one to one or two to one, so that appropriate staff levels could be allocated to meet people’s needs as well as their goals.

Requires Improvement

Is the service effective?

Our findings

When we last inspected the home in April 2014 we found the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) were not being met. At this inspection staff demonstrated an understanding of lawful and unlawful restraint and had a working knowledge of the MCA and DoLS. We saw staff had followed the requirements of the MCA where people were unable to make important decisions about their health.

Best interest decisions had been made with other professionals for regarding people's health. However further improvements were needed because this was not consistently applied to other aspects of people's lives. For example the provider had not considered people's capacity or the least restrictive options when supporting a person during the night time. We also saw proper consideration of DoLS guidance was needed where a person's choices placed them at risk. For example leaving the home but was not safe to do so. Whilst we saw risks to the person had been addressed from a safety perspective; there was no formal assessment of the person's capacity. We were informed that this was to be arranged. We saw that no one had a DoLS authorisation.

We saw that people were mostly asked for their consent before assisting or supporting them. We heard staff explain options to people to help them understand before undertaking tasks with them. People told us they made their own daily choices where they preferred to stay in their bedroom or flat and that staff asked their consent before entering or providing support or assistance.

When we last inspected the home in April 2014 the provider was not ensuring that changes in people's health were acted upon. At this inspection we saw people were supported to maintain good health. Referrals had been made to health professionals where people's health needs had changed or deteriorated. For example we saw that staff had sought assessments of people's nutritional needs where their ability to swallow was compromised. We saw recommendations and guidance was available to staff from the speech and language team, [SALT]. Staff we spoke with were aware of the signs to look for if there was deterioration in a person's ability to eat or drink and the support the person needed was available in the person's care plan. We also saw at lunch time that staff followed the care plan for one person by ensuring the person was correctly positioned to ensure they could eat and drink safely. However there was a need for consistency as we saw another person did not consistently receive the one to one support they needed with their eating.

Links with other health professionals such as the epilepsy nurse and specialist advisors from the community learning disability team were evident and we saw people had access to routine health check-ups. Whilst we found the provider had taken preventative action to keep people in good health further improvement was needed in terms of keeping people's health under review.

People that we spoke with told us that they were happy with the way staff supported them. One person told us, "I think the staff are good, they know how to help me". Relatives were complimentary about the abilities and skill of staff in understanding and meeting people's needs. One relative told us, "The staff always seems to understand [name of person] and I have no worries they meet [name of person] needs". A second relative told us, "This is the best place [name of person] has been; the staff are extremely good and skilled in understanding their needs and how to meet them".

Staff told us they had been supported to understand their role, and described their induction as helpful. Other staff told us the complexity of people's needs was not covered at their induction. One member of staff told us, "My induction covered the basics mostly the routines, getting to know people and some procedures". The provider told us they were improving the induction process so that staff could be consistent in their roles.

Staff told us they were happy about the training they had received. One member of staff told us, "I've had lots of training since I started working here." We saw that most staff had undertaken a range of training in core areas such as epilepsy and autism. However some training specific to the needs of people at the home was needed. This included dysphagia training to ensure staff understood the guidance from the SALT team where people had difficulty swallowing. The provider told us they were taking action and that dysphagia training was being sought. We also saw immediate action had been taken to instruct staff on the management of PEG feeding (a feeding tube through the stomach wall), to ensure staff knowledge and skill was up to date.

Requires Improvement

Is the service effective?

The staff team had expanded and people who lived there had a range of complex and specialist needs. We identified staff did not have up to date training in managing people's behaviour. We saw they focused on people's behaviours and tasks rather than the individual person. There were examples of removing a person from the table due to their behaviour and a lack of agreed interventions for supporting another person's behaviour at night. This indicated staff did not always have the skills or training necessary to working with people with complex needs. We saw there had been two incidents reported about staff care practice and these were under safeguarding investigation. Care plans did not contain sufficient guidance to staff on how to support a person with their behaviour without potentially compromising the person's safety. We discussed this with the provider who told us they were going to review staff training and had sourced links with training companies to prioritise this. He also told us on the second day of our inspection that guidance and instruction had been provided to staff to support a person during the night.

We observed lunch being provided to people. One person told us, "The food is alright we always get choices; I'm having fish today." A relative we spoke with told us, "[person's name] is really happy with the food, gets plenty of variety, and gets a choice". A person told us, "I don't really like the food there's not much of a choice". No menus were on display to show people the options for the day but we saw people were asked what meal they preferred. Information about people's nutritional needs was known; and people's diets which included weight reducing diets, pureed diets and the foods people could not have due to their medicines or medical conditions, were catered for. People's cultural dietary needs had been met and we saw staff had sufficient guidance to ensure food for religious or cultural needs was prepared in the correct manner for example by using separate utensils. An outside supplier provided a specific diet for one person. Although we saw people enjoyed their food, the meal experience was quick and functional; staff were observed going in and out of the dining room throughout and did not sit with people to try and make it a more relaxed and enjoyable experience. Tables were not laid with accoutrements so people did not have an option to independently help themselves. People were offered a regular choice of drinks throughout the day. Some people we spoke with confirmed that they had support to prepare and cook their meals.

Requires Improvement

Is the service caring?

Our findings

One of the people that lived in the home told us, "Staff are good but I prefer to stay in my flat". Prior to the inspection we were informed that the attitude of some staff and the way they spoke with some people had not been caring or appropriate. No one we spoke with shared negative views with us. A relative we spoke with told us, "Staff are kind to [name of person] and take time, understand [name of person's] sense of humour and do their best". Another relative said, "[Name of person] absolutely loves it and so do we. We took [name of person] away and by the last day [name of person] wanted to come back, these are [name of person's] friends, community, and [name of person's] life is fantastic."

Staff we spoke with provided examples of how they upheld people's privacy. We saw that when people needed assistance with personal care staff supported them to their bedroom or bathroom and closed the door for privacy. We saw staff encouraged people in a respectful way when prompting them about their appearance or dress. Staff were able to explain the individual needs of people and people's personal preferences. For example they told us about a person's preference to continually change their clothes. Staff recognised this as part of the person's behaviour and we saw they complimented the person who responded with a smile. We spoke with the person who showed us their bedroom and proudly showed us their clothes; we could see that the things that mattered to them were respected by the staff.

We saw that staff knew people very well; they could describe people's characters and emotional needs. One staff member told us about how they had recognised a person's low mood and we saw they were attempting to encourage the person and spend time talking with them. People told us that staff respected their privacy, one person said, "Staff ask and knock the door before they come into my flat". There were examples that demonstrated some staff did not understand how to uphold the key principles of respect and dignity for people. On one occasion a person's dignity was compromised with food spillage down their clothes and on their table. We did not see staff attend to the person to support them with their dignity. We saw a person was moved to another dining room part way through their meal. When we asked a member of staff why, they told us, "The person does this [referring to the person's behaviour] deliberately for attention". There was no record on the person's file to state this was the support they needed, we concluded that staff were not supporting this person in a caring way. The provider told us that as part of their proposed training plan they would be including training on values so that all staff understood the principles of good care.

We saw positive examples of staff speaking to people in a kind manner; lowering their voice and speaking in an encouraging way. We observed staff interacted with people in a friendly manner and people responded and engaged in conversations with staff. Other people unable to articulate their views responded with smiles and gestures which indicated they enjoyed the interaction. We saw staff encouraged people who in turn engaged in a spontaneous singing session. A staff member said, "[name of person] loves this; we start the song they finish it".

We saw a staff member was regularly observed to support a person to walk independently and this was in line with the person's care plan. We saw the person enjoyed this because they were humming and singing. Staff responded to people when they became distressed and diffused situations where people had verbal conflict so that people were supported to do the things they wanted. Some people told us they were happy living at the home, one person said, "I'm happy living here, the staff are good and I can do the things I want".

Staff had a good understanding of people's life history, their communication needs and personal characters. We saw examples where staff used this well to talk with, support and motivate people. However there were gaps in people receiving personalised care and support because a full account of their needs was not in place. For example ensuring that people's preferred routines for going to bed, getting up or how they spent their time, were established with them. We heard from staff we spoke with how they had recognised areas where people had been isolated, vulnerable or unable to manage aspects of their care. Staff had reported concerns and we saw the provider was taking action alongside the local authority to ensure people's independence was assessed in order to have the full support they needed.

Some people told us that they were happy about the level of independence they had. They told us they had been supported to make decisions about going out, shopping and cooking. Staff we spoke with demonstrated a good

Requires Improvement

Is the service caring?

insight into people's characters and this informed the approach they took to support people. A relative told us, "I think [name of person] has been respected as a person, encouraged to use their initiative and feels safe and secure". A person told us that they had enjoyed attending external amenities such as college and another person told us about music lessons they had. A relative of a person told us that these opportunities were important to the person's well-being. Records showed that people had attended activities outside the home in order to promote social interaction. We saw involvement of advocates was evident where some people may have no one to advocate for them regarding decisions.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in April 2014 the provider had not ensured people's care was delivered safely in line with their assessed needs. At this inspection we found that arrangements were in place to identify people's needs and details about how to manage risks to people's health were recorded in their care plans and risk assessments. However further improvement was needed to ensure staff followed the procedures in a timely way to manage people's risks. For example specific equipment necessary to manage a person's health condition had been broken. If staff had followed the care interventions as outlined in the person's care plan this would have been detected earlier. Whilst we saw the provider had replaced the equipment no steps had been taken to ensure staff followed the guidance to prevent a recurrence. We brought this to the provider's attention on day one and he took immediate action to ensure that staff were clear about the interventions needed. Additionally the provider put in place a monitoring record so that the management oversight of the person's health needs was tightened.

People told us they had attended meetings to discuss their care. One person said, "I talked about what I wanted and the staff helped me to do stuff". All of the relatives we spoke with told us they were involved in the planning and review of their relative's care. One relative told us, "They are so good with [name of person], they have sorted out all the problems we've had very quickly".

Our discussions with staff showed that they knew people well and understood their needs and preferences. Some of this information was recorded in people's care records; information about health needs and interests was included. However care plans did not always include sufficient personalised information detailing how people wanted their needs met such as bedtime routines. For people who were unable to vocalise their preferences more information was needed to reflect how their routines and preferences had been established and how they had been enabled to be involved with the planning of their care. For example staff told us they had recently changed the daily routine for one person and were able to describe the benefits for this person. When we asked why this had not been done before they told us they had not been consulted with regard to the care plan and what worked for the person. We saw this person was enjoying the new routine.

Staff told us about their concerns regarding another person who had moved into the home. They described incidents of potential risk that they said they had raised but that they were not listened to. We found the person's assessment and care plan did not fully identify the person's needs. We saw the changing needs of the person had not been reviewed promptly so that the person received person centred care. The provider had taken initial steps to reduce some risks and during the course of the inspection we saw the person's immediate safety needs had been addressed. The person told us they were happy with the new arrangements.

The system for reviewing care plans was not robust because it had not highlighted the changing needs of people. We could not see from the care records or our discussions with staff that relevant external professionals had been involved in the review of people's complex needs. For example care plans lacked details and guidance about people's specific needs such as the most appropriate way to manage a person's behaviour without compromising the person's safety. People's opinions with regard to their needs or wishes were not being consistently sought to develop a personalised care plan. A senior member of staff told us, "It has been difficult because we haven't really been included in developing people's care plans or encouraged to discuss care interventions".

We saw that people had opportunities to engage in activities they enjoyed both inside the home and in their local community. During the day some people preferred to occupy themselves such as watching DVDs or listening to music. We saw other people engage in quizzes and art provided by the staff. A sensory room was available where people could relax and enjoy music and visual stimulation. People told us that a masseur also visited and that staff at times took them out for lunch or to the pub. We heard staff encouraging one person to engage in planning a meal out organised for later in the week. We saw staff supported the person to overcome some of the obstacles they were presenting. The person told us, "I don't like eating meals in public but I'm going to the pub to have a meal". We saw staff shared and discussed the pub menu with the person and responded with appropriate reassurance to their anxieties.

We spoke with people about the things that mattered to them. People told us they had been asked about the things they would like to do. One person said, "They asked me

Requires Improvement

Is the service responsive?

what I'm interested in and said they will organise it". One person told us, "I would like to go to college to do art; staff said they will help me". A member of staff said, "We do support people with going to college or courses but we could be more proactive and ensure they are doing the things they want to do". Another staff member told us, "Some people did get bored, people's activity goals weren't happening but recently we are finding out from people their likes and dislikes and this is happening now and people are happier". We saw examples of improvements such as applications for bus passes and lists of people's interests and activities being developed. One relative told us, "I feel the staff have helped [name of person] and enabled us to be integrated into [name of person's] care". Another relative said, "There has been progress on personalised care planning, I've been in meetings and involved".

People had been involved in meetings to discuss events important to them. People told us they had been asked their views about the service in house meetings as well as surveys. They had discussed holidays, activities and changes to the service such as the extension and new people moving in. One person said, "Staff are good, management are good. We have meetings once a month they tell us what is coming up and you can ask questions." People told us they could speak to the provider who regularly visited and to staff. One person told us they had been involved in staff interviews.

People and relatives we spoke with knew how to complain. One person told us, "I would tell staff or the owner". We saw some people had used this process and the provider had responded appropriately, which was confirmed by a visitor we spoke with. However the record of complaints was not well maintained because there was no evidence of the outcome of some of the complaints and people did not have access to a complaints procedure in a format to meet their needs.

Requires Improvement

Is the service well-led?

Our findings

We last inspected this service in April 2014 and found the provider was not meeting the requirements of the Health and Social Care Act 2008. The systems in place to monitor the safety and quality of the service were not effective. Following our inspection the provider submitted an action plan detailing the work they would undertake to improve the quality and safety of care to people.

At this inspection we found some improvement had been made because the provider had obtained the services of an external consultant to further develop the systems needed to monitor the quality of the service. The systems in place had not identified the issues we identified at this inspection and needed further strengthening to ensure the risks to people's health and safety were identified and managed. For example further improvement was needed in relation to the auditing of people's medicines to ensure they were safe to use. As a consequence we found that a medicine that was required for use in an emergency was out of date. We also found the safeguards in place for managing a person's health condition had not been followed and as a consequence the person did not receive the care they needed to keep them healthy. Medicines were not being monitored correctly so they would be effective. For example the maximum and minimum temperatures of both refrigerators were not being measured and recorded. It was particularly important to monitor the maximum and minimum temperatures of the fridge storing the insulin because poor temperature conditions would affect how the insulin worked. A more proactive approach to quality monitoring was needed to enable the provider to identify what needed to be done.

At our previous inspection in April 2014 we found that people had not been protected people against the risk of receiving unsafe or inconsistent care because records detailing how people's risks should be managed were not up to date. We found that no improvements had been made in this area. For example we saw an incident had occurred that resulted in an injury to a person had only been recorded in the daily records. No accident log or incident log or body map had been completed. We spoke to the deputy manager who was unaware that a person had been hurt and was not aware of the entry in the daily records. The incident had not been communicated at the shift handover which was also not recorded. This injury was subsequently reported to the safeguarding team for investigation.

Similarly we saw staff recorded accidents and incidents such as falls in people's daily records but these had not been reviewed. We spoke with the deputy who could not evidence that appropriate action had been taken in response to a person who had fallen. They were unable to tell us if advice from the falls team or occupational therapist had been sought. The records of the visits from health care professionals were not easily located which made it difficult to establish if health issues had been followed up. Staff we spoke with had acted upon some people's changing health but this was following external prompting. Relatives told us that they had no concerns about health care support. A person living there told us, "If I'm sick or need to see someone the staff arranges it. I see lots of people".

There was a lack of systems to ensure management had a good oversight of the home. We noted that the format of the night records meant staff recorded minimal information about people's support needs which in turn reduced the provider's capacity to fully review and act on changes, concerns or incidents. We spoke with the provider about the records and on day two of the inspection he showed us a new recording log he had implemented. He had also issued guidance to staff about the information they should record. We found that written information available to the staff for the administration of when required medicines was not robust enough to ensure that the medicines were given in a timely and consistent way. This information was particularly important because the people who use the service had difficulties in communicating with staff.

The provider told us they were intending to review people's care records and the systems for checking these to ensure accurate information was available about people's needs. We found that the provider's arrangements for taking reasonable steps to maintain accurate records related to people's needs had not been sufficient and there continued to be a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

The key challenge at the home was the management arrangements. The provider had a registered manager but she had not worked at the home for several weeks and was not present at the time of our inspection. We saw the provider had taken action to provide interim management arrangements but we found these to be lacking in terms of effective leadership and oversight of the service. We discussed this with the provider who informed us they had recruited a temporary new manager who was due to start work in the coming weeks. In the interim we saw both the provider and the consultant with the services of the provider's PA had been working in the home to support the immediate improvements needed.

We saw the provider and consultant were working with the local authority to address some of the concerns and was undertaking internal investigations into the conduct and performance of individuals working in the home. The provider had already implemented actions and told us about their plans to make further improvements. For example introducing a system to analyse the number and type of accidents and incidents occurring in the home so that patterns or trends could be identified and risks reduced.

The provider had developed opportunities to enable people who lived at the home and their relatives to share any issues or concerns. We saw questionnaires had been sent to people who lived at the home, relatives and visitors on a regular basis. The provider told us he had regularly spoken with staff and people in the home about their experiences and had always had positive feedback to help him to monitor people's satisfaction with the service. Feedback from relatives about the quality of the service was positive. All of the relatives we spoke with told us the staff team were friendly, professional and caring. Some relatives described positive changes for their family member as a result of having a 'good quality of life' at the home. All of the relatives told us they felt their family member was safe and well cared for. One relative told us, "The owner is very good, very supportive I can phone him any time if I needed to".

In the absence of the registered manager the provider had demonstrated an understanding of their responsibilities for notifying us of incidents that may occur or affect people who used the service. We had been notified of the changes to the management structure and interim management arrangements.

Although staff had received training there was no effective means of reviewing training to ensure staff had the right skills and competences to meet people's complex needs. The provider told us they were in the process of reviewing staff training to ensure they had the skills to meet people's needs.

Staff spoke positively about the changes that had recently taken place describing positive staff morale and positive impacts for people. They had described the culture in the home as previously oppressive; feeling unable to contribute to developments or challenge practices. One staff member told us, "We didn't have confidence that we were listened to". Another told us, "It is getting better because now we are being asked what needs to change and encouraged to make the changes, like getting people more involved in the things they want to do". The provider told us that they planned to increase the opportunities available to staff so that they had regular opportunities to discuss and develop their practice through staff meetings, handovers and training. Staff understood how they could report their concerns about the care offered by colleagues via the whistle blowing procedures. We saw the provider took effective action during our inspection where this had occurred.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 17 HSCA (RA) Regulations 2014 Good governance. The provider had not maintained accurate records related to people's needs and there continued to be a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.