Irvine Care Limited

Coombe Lodge Care Home

Inspection report

Nash Lee End, Wendover, Aylesbury,
Buckinghamshire, HP22 6BH
Tel: 01296 696944
Website: www.fshc.co.uk

Date of inspection visit: 18 & 19 March 2015
Date of publication: 19/05/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

Coombe Lodge care home provides nursing care for up to 60 people, including people with dementia. The service has two units which provide nursing and dementia care. The service is set over two floors. At the time of the inspection, 33 people were living at the home.

Coombe Lodge had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, we were told during the inspection that the registered manager had left the service.

During our Inspection of the service in August 2014 we found that the provider had not met the requirements of the law in the following five areas:

- Care and welfare of people who use services
- Management of medicines
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision

Summary of findings

During this inspection we found that improvements required at the service had not been made.

The service has had two registered managers and a further two interim managers during the past year. The senior management of the home has also changed during this time. We found that these changes along with a high turnover of nurses working at the service had contributed to the service not improving.

The care staff lacked any clear leadership from the nurses, management or senior management of the service. Despite the dedication of the care staff they were unsupported in their roles. This had led to the staff team working in a task orientated way and meant that people living in the service were not being supported in a person centred way and were at risk of their needs not being consistently met.

The service provides people who live with dementia. Throughout our inspection we saw little evidence of good practice in relation to supporting people with dementia. This included poor training and support for staff in this area. We found that this led to care staff providing support in the way that they thought was best, due to the lack of effective guidance and training.

We found that many people living in the services were at a high risk of falls and that these risks were not being managed appropriately. This had led to a high number of falls that people sustained at the service.

Some people living at the service had behaviours that could challenge staff, themselves and other people living in the home. We found that people were not always protected from the behaviours of these people. This has led to a high number of safeguarding incidents in which people have been harmed by other people living in the home. Although these incidents have been reported to the appropriate authorities, little has been done to prevent these incidents from re-occurring.

The various managers and senior managers of the service have carried out regular monitoring of the service. However, they have failed to address the concerns that we have found in this service.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were not always knowledgeable around their roles and responsibilities when working with people around consent and the Mental Capacity Act 2005 (MCA). Some staff were not able to explain what the MCA and DoLS meant, and how this affected the people they worked with. We found eight people on the ground unit who were being deprived of their liberty without the correct legal processes in place to ensure their rights. Where required, mental capacity assessments were completed along with evidence of best interest meetings, however these were not followed up when it was evident people that people were being deprived of their liberty.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to the regulations 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were put at risk as staffing levels in the service did not reflect the needs of people living at the service.

We received a high number of safeguarding alerts prior to our inspection which indicated people were potentially placed at risk.

Medicines were managed in a safe manner.

Is the service effective?

Inadequate

The service was not effective.

Supervision meetings for staff were not undertaken in line with the provider's policy. Staff told us they did not feel supported in their roles.

People were being deprived of their liberty unlawfully. Staff's understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was poor.

People were at risk of not having their nutritional needs met.

Is the service caring?

Requires Improvement

The service was not caring.

People were not always treated with dignity and respect.

End of life care plans did not record people's wishes or requests.

We saw limited evidence of how the service was adapted the care provided to meet the needs of people with Dementia.

Is the service responsive?

Requires Improvement

The service was not responsive.

Some care planning had improved to reflect people's needs.

Activities were selective. We saw people in bed for long periods of time with no social stimulation.

Relatives meetings were undertaken regularly, however we saw no evidence of how people's views and comments fed into the service.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not respond to our request to send a copy of their training matrix so we could see if staff were trained appropriately.

Summary of findings

Management was not always clear with staff and relatives about current issues within the home.

The service had no clear leadership or management in place. Since our inspection in August 2014, only minimal changes had occurred.

Coombe Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 18 and 19 March 2015 and was unannounced.

The inspection team consisted of three inspectors. This was due to concerns raised by the local authority and people who visited the service. We also followed up on concerns from the services last inspection which included people's dignity and welfare, staffing levels, concerns around medicines and concerns around the quality of the service.

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. We received a PIR form from the provider. We checked to see what notifications had been received from the provider since their last inspection. Providers are required to inform the CQC of important events which happen within the service.

During both days of our inspection we spoke with the interim manager, two nursing staff, seven support workers, four relatives of people and domestic staff including the chef. We undertook observations of staff practice over the two days. We reviewed six care plans, medicine records for people living on the ground floor units, daily records including turning charts and food and fluid charts, six recruitment files and copies of quality monitoring undertaken by the registered manager. We also looked at staff supervision records, training records for all staff and induction records for new members of staff.

Inadequate

Is the service safe?

Our findings

The services last full inspection report was not on display for staff members, relatives, people and visiting professionals. This meant people may not be fully informed about the concerns raised at the service's last inspection in August 2014.

At our last inspection, we raised concerns around how people's needs were met as no call bell extension cords were in place for people to use. We were advised at the last inspection these had all been removed due to a serious incident; however no effective arrangements were in place to ensure people's needs were met and they could obtain assistance when needed. At this inspection, we still found concerns. Call bell extensions were still not in place. We noted one hour monitoring charts were in place within people's rooms; however these were not filled in. We noted one person had a call bell extension cord however; this was tucked behind a tap and would not have been in reach if someone had fallen in the bathroom. A staff member told us "They [people] are unable to understand how call bells operate or what they are for." This meant in nine months, no effective arrangements had been put in place to ensure people's needs and requests were met in a timely manner.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people living at the service had behaviours that could challenge staff, themselves and other people living in the home. We found that people were not always protected from the behaviours of these people. This has led to a high number of safeguarding incidents in which people had been harmed by other people living in the home. Although these incidents have been reported to the appropriate authorities, little has been done to prevent these incidents from re-occurring.

At our last inspection, we raised concerns around the number of staff available to assist people. This had not been addressed since the concern was raised 9 months ago. Prior to this inspection, we had been informed by the local authority and health professionals that people were placed at risk due to unsafe practices. We also received information of concern from people who visited the service including unexplained bruising and marks. This included unsupervised falls resulting in people being injured where no staff were around to support people. Due to these concerns, the local authority was visiting the service on a daily basis to ensure the welfare of people who used the service. Staff told us they were aware of what safeguarding vulnerable adults meant, and how this applied to their role, however due to the amount of safeguarding notifications received and concerns raised by other professionals, we found people were not always protected against the risk of abuse and potential harm.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt there was not enough staff to support people. Comments included "It's the staffing that's getting me down, we are supposed to have five staff on the unit however with staff leaving and two staff being used for one to one care, we are really short" and "We are too short staffed, there's not time to do everything." Throughout our observations, we noted staff were visibly stressed when undertaking their duties. For example at lunch time staff appeared tired and agitated whilst supporting people.

On the ground floor unit, two staff members had been removed from the unit's numbers to provide one to one care for two people. These two staff members were not replaced in the numbers which meant three staff members were providing care to 18 people, most of whom required support from two staff members. Throughout the day we noted periods where we saw no visible staff due to them supporting people. At lunchtime, we noted people were waiting for considerable periods of time for their lunch.

We were provided with staffing rotas for the previous four weeks to check staffing levels. We found there to be sufficient numbers of staff on the first floor to support people. However, on the ground floor, we found six occasions where minimum staffing numbers were not met. For example, only four staff members were working. This meant only two staff were available to support people on the ground floor, as the extra two staff were required to provide full time one to one support for two people who used the service. One relative felt staffing was very inconsistent particularly with the nursing staff and staff often didn't know who they were. Another relative told us

Inadequate

Is the service safe?

on many occasions they had seen other people beginning to get upset or confused and had to talk with them and direct them to the lounge or their rooms as no staff were around.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's medicine records and medicine administration for people on the ground floor. Medicines were administered by nursing staff who were trained in undertaking tasks relating to medicines. We found the process of medicine administration had improved since the services last inspection. Medicines were recorded and signed for using a Medicine Administration Record (MAR) when they had been administered. When medicines had not been administered for specific reasons, the reason why was clearly recorded. Temperature checks were completed daily including fridge and room temperatures.

Guidance was in place for the use of 'as required' (PRN) medicines, however this was not evident for all people who used PRN medicines. A new system was implemented to check people's MAR charts and count medicines after each medicine round to ensure they were accurate and correct.

Controlled drugs were stored in appropriately and corresponded with people's controlled drug records and their MAR charts. Controlled drugs were signed by two staff members and regularly stock checked.

We looked at six recruitment files for staff members. Recruitment files contained a new starter checklist to ensure all relevant documentation was on file. All six files contained a photograph of the staff member and proof of identity. Medical histories and previous employment histories were in place with relevant gaps in employment explained. Copies of staff Disclosure and Barring Service (DBS) checks were kept on file including the date they had been received. All files contained evidence of satisfactory conduct in previous employment. Where applicable, nurses pin numbers were recorded which showed their eligibility to work.

Appropriate risk assessments were in place where it was assessed people were placed at potential risk, for example, choking. However, we found minimal risk assessments around people who were at risk of falls, especially as this had been highlighted previously as an issue by management and other health professionals. Where people were at risk of weight loss, the risk had been assessed and a plan of action was put in place to address the risk, however we found this did not always reflect practice as staff told us they did not always have time to provide people with drinks and people's food was often left in front of them with no support. We found risk assessments in place for some people regarding the lack of call bells; however this was not consistent in all care plans as we were advised no one who lived at the service was able to use a call bell.

Inadequate

Is the service effective?

Our findings

The service provides care and support for people living with dementia. However, we found that the service was not effective in delivering specialised care and support to people living with dementia. The service was not able to demonstrate how good practice in dementia care was passed on to the staff team. Staff we spoke with told us they felt adequately trained to undertake their roles. One staff commented "We have had a lot of training lately, especially from health organisations which has been good." Another staff member told us they had done online dementia training with this service and other dementia training with previous organisations. Another staff member told us they were currently updating their mandatory on line training. They told us the only dementia training they had done was online. They also told us they hadn't done any person centred training. One staff member told us most training was completed via e-learning which they "are not a fan of."

We found supervisions did not always demonstrate a two way discussion and focused on the service and staff duties. This had not improved since our last inspection. Staff told us they did not always feel supported. Comments included "I think a lot of staff are feeling pressured. There is no teamwork on the ground floor. We raise stuff all the time but nothing is ever done", "We just get on with it", and "We are not being told anything, we have all these managers here but don't know who is who or what's happening." Staff told us they had not received supervision recently. One staff member told us they had received supervision two or three times in the last year. One staff member was unable to identify who their supervisor was. We were advised by the Interim manager supervisions were supposed to occur bi-monthly, however the services staff supervision record showed supervision was inconsistent. Staff who started work in November and December 2014 had not yet received supervision. Out of 46 staff members listed, only 15 had been recorded as receiving supervision since January 2015.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff struggled to demonstrate an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest meeting is held to ensure the decision is made involving people who know the person well and other professionals, where relevant.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people were potentially deprived of their liberty, the correct process had not been followed to ensure people were not deprived unlawfully, for example, one person received 24 hour one to one care which potentially deprived them of their liberty unlawfully. The interim manager was unable to explain why an application to the supervisory body had not been made.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had concerns that people's nutritional needs were not always met. We noted staff shortages over the lunch period and some people waiting over 20 minutes to receive their lunch. One person refused to eat their lunch and staff did not apply any strategies to encourage this person to eat. This person's care plan stated they were at risk of weight loss. The service had made a referral to the dietitian, however no intermittent strategies were in place to ensure they had enough to eat and drink. We noted another person who had recently lost weight was left over the lunch period to walk around the unit, rather than try and promote effective strategies to encourage them to eat. One staff member told us "We still struggle to have enough time to get people to drink." We saw staff were visibly stressed over the lunch period whilst trying to assist people to eat due to staff shortages.

We spoke with the chef about catering and how people's food intake was monitored and recorded. They told us there was a tick list in the kitchenette. This recorded whether and what people had eaten. Staff told us they had implemented milkshakes as recommended by the dietitian to improve people's calorie intake. People had fluid and food record charts within their personal files, however fluids were not always listed as being given and we saw one staff member completed a food chart for someone who they had not witnessed eat. People's care plans listed

Is the service effective?

their nutritional needs which included the use of a **Malnutrition Universal Screening Tool** (MUST) to assess where people were at risk of weight loss or malnutrition. However, in practice, we found people were not always supported to eat adequate amounts of food and drink. One relative we spoke with told us "They gave X toast but X doesn't have any teeth so can't eat toast." We saw people were regularly left with food and fluids in front of them but were not assisted to eat or drink. We observed one person wandered into another person's room and ate their biscuits. The same relative told us "X has a good appetite but if it's left in front of them, X won't eat. X needs encouragement."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had links with a local GP surgery. The GP visited weekly to address any medical concerns which had been identified by staff or relatives. We saw outcomes of appointments were clearly recorded, however clear instructions for further action was not always clear. For example, One person saw the GP for 'sticky eyes'. The instructions for how to deal with the persons eyes was recorded as 'eye care' by the nurse with no specific instructions on what eye care should be provided. This meant people may have been placed at risk as there were no clear instructions on how people's medical conditions were to be managed.

We found areas of the home were in need of refurbishment. We found the home contained areas which were not clean, this included the communal bathrooms. People's rooms had wallpaper chipped off the walls and paint was chipped off furniture. The communal areas were in need of decoration to improve the look of the service. One staff member commented "I wouldn't put my mum in here; it's not homely at all." We found limited use of dementia friendly aids such as memory boxes or sensory items.

Throughout both days of the inspection, we noted strong odours throughout the service. The service had two housekeepers cleaning on both days of our inspection who were consistently cleaning, however we did note periods when cleaning trolleys were left unattended. On our arrival, we noted faeces on one person's bed. This was not detected by staff for over 30 minutes until the person was supported with their personal care. During lunch we observed one person's lunch had fallen on their apron. The person then ate their lunch of their apron. The staff member supporting the person witnessed this and took no action. This did not indicate good infection control practices. We also observed housekeepers cleaning up spillages with their cleaning trolleys whilst people were eating their lunch. One person spilt their drink which staff members witnessed and was not cleaned up for over 15 minutes.

Requires Improvement

Is the service caring?

Our findings

We found people were not always treated with dignity and respect. On arrival to the service, we noted one person was still in their nightgown. The person lifted their nightgown and exposed themselves, but staff did not react to protect the person's dignity. We asked staff if this person used any continence aids and were informed they wore incontinence pads. However, we noted this person not to be wearing their continence aid.

During lunch, we made observations of how staff supported people to maintain their dignity and promote respect. We observed some positive interactions, for example a member of staff holding a person's hand whilst they were eating to provide comfort. However, we observed poor practices relating to dignity, for example, one staff member was observed placing food into a person's mouth when they appeared to be asleep. We also noted one staff member supported a person to eat. When the person stated "no", the staff member responded with "yes" with no gentle encouragement. We observed one person who was served their lunch at 12pm in their room. When we revisited their room at 1pm, we found food on the floor which had not been cleared up.

Staff did not always respect people by waiting for their consent before undertaking tasks, for example, offering drinks. We found staff placed protective aprons on people without their consent or permission. We observed one person ate their food off their bib without staff intervention. We observed people's lunch left in front of them with no support or encouragement to eat. During lunch, we saw staff were visibly stressed and agitated.

We observed one person walked around with one slipper, and another person without any socks or footwear on their feet. We found one person had a full cold cup of coffee in their room on their table. We noted later the person was sat in the lounge with another cold cup of coffee on the table next to them. We observed one person being pushed up to a table in their wheelchair. As staff were bringing other people in, this person has calling out for help and standing up from her wheelchair which was almost falling over. The person was reassured by staff who were coming in and out but had to wait nearly 20 minutes for their lunch to be served.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found documentation in place for end of life care, most care plans we looked at stated that people were to be supported with their end of life care with no reference to people's wishes or preferences in regards to end of life care. However people were not on end of life care at present so the care plan was not applicable. This demonstrated poor practice in relation to promoting people's wishes around their end of life care and ensuring advanced decisions were upheld.

Although the service was involved in a dementia programme called 'Positively Enriching And enhancing Residents' Lives' (PEARL) since 2012, it had not yet been fully implemented. Staff told us they had received dementia training; however we found poor dementia practices and awareness. We found nothing in place to promote people's lives who live with dementia to ensure their voices and feedback was implemented into the service. We found people in bed for significant periods of time with no social stimulation.

Requires Improvement

Is the service responsive?

Our findings

We found there had been some improvement to people's care plans since our last inspection in August 2014. Care plans were broken into specific sections such as nutrition, capacity, medication and personal care and most were reviewed monthly to ensure where people's needs had changed; these were reflected in their care plans. However, we found clear guidelines were missing for example, people who required one to one care, how this care was to be provided and the reasons why. We noted a visit on 12 January 2015 in which the GP felt that one person was at the end of life stage. This was not reflected in their care plan which had not been reviewed since 8 January 2015.

We saw some evidence of person centred planning, for example, people's likes and dislikes were recorded in their care plans. Some people had memory boxes outside of their rooms which gave information about the person and their history, but this was not evident for most people who live within the service.

We saw a range of activities were available for people who used the service. Activities were displayed within the home and showed what activities were available and when. We saw people participated in activities such as music therapy and celebrated a birthday. At our last inspection, we had concerns that activities were not offered to all people within the home. We found the same concerns at this inspection. People were in bed for long periods of time with no social stimulation. Where people were receiving one to one care, there was limited interaction, for example, one person was sat in the nurses office with a member of staff who observed them. There was no conversation or social stimulation.

We looked at copies of staff and relative meetings. One relative we spoke with told us they did not get much notice to attend a relatives meeting. The last relatives meeting was dated the 19 February 2015 which listed what activities and events had taken place since the last meeting; however there was no documented input from relatives. We saw staff meetings occurred regularly and had focused on recent issues raised by the Commission, the local authority and professionals; however there was no clear action in regards to issues raised. We saw no evidence of how people's views and input fed into the service.

The service had a complaints policy in place which was visible to people using the service, relatives and visitors.

Inadequate

Is the service well-led?

Our findings

At our previous inspection of the service in August 2014 we found that the provider was not meeting the requirements of the law in relation to how the service provided was monitored. The provider told us how they would make improvements and when they would be meeting the requirements of the law in this area. During this inspection we found that required improvements in this area had not been met and we found the service was not well led.

We requested a copy of the service's training matrix so that we could we could check that staff had received appropriate training on three occasions. A copy of this was not sent to the Commission. We were provided with no reasonable explanation as to why this document was not sent.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw little evidence of how people, those important to them and staff were actively involved in developing the service. Relatives told us that meetings for relatives were advertised in the service, often at very short notice which made them difficult to attend. The provider told us that a new system was being implemented at the service to gather feedback from people, staff and their relatives. This involved the use of a tablet computer and a kiosk in the reception area in which feedback could be left, anonymously if the user wished. We were told that the system worked well in other homes and was being rolled out to all the provider's homes.

Care staff told us they could raise concerns with management about how the service was run. However, they told us this was difficult due to the changes in management, senior management and nurses. During our visits, the provider had allocated senior management to attend the service to address the issues raised, however staff told us they did not know who the senior management was, what they were doing at the service and why they were there. One staff member commented "We have all these managers here but I don't know who they are."

One relative told us shortly after our inspection in August last year, they spoke with a nurse who was visibly upset. The nurse told them that they and the staff team were being blamed by senior management for the findings of that inspection. Incidents like this do not promote a positive culture where staff are able to raise concerns with senior managers. Staff meeting minutes viewed concentrated on negative issues and did little to promote values or good practice. There was little evidence of staff receiving feedback from managers in a positive way. We observed two occasions when the interim manager instructed staff to do things in an abrupt way in front of the inspectors and other staff.

The provider through its policies and procedures has a clear set of values and a clear vision for the service. However, these are not promoted effectively to the staff team working at the home. Care staff were not familiar with these values and their implementation is not monitored by the management of the service. This has led to the staff team developing their own culture and the service being run by members of staff in a task orientated way. Where staff concentrate on ensuring that the daily tasks that need to be completed, such as supporting people to get up are achieved in the easiest way for the staff team. This has led to people having washes in their rooms as opposed to being offered showers or baths as stated in their care records. We saw that care staff were not following people's wishes expressed in their 'preferences' document kept in people's rooms.

Neither good management or leadership was demonstrated in the service. The service has had two registered managers and two other managers in the past year. Currently the service is being managed by a peripatetic manager who had returned to the service on the 27 February 2015 to support the registered manager. During the inspection we were told that the registered manager had left the service. We also found out following the inspection that a more experienced interim manager would be replacing the current interim manager on the 23 March 2015.

Staff told us they had struggled with the changes in management. One staff member told us "Everything is a muddle; it would help if we had a manager in place." Relatives we spoke with were also concerned about the management of the service. They also commented staffing was an issue and staff didn't know who they were. Another

Inadequate

Is the service well-led?

relative told us about the Management and the senior management of the home. They said "They [management and senior management] were awful and always changing with no consistency."

Since our inspection in August 2014 the provider has had six meetings with Buckinghamshire County Council (BCC). We have attended several of these meetings in which senior management from the provider had also attended. Throughout this time there has been no consistency in the representation from the provider and several changes in area manager and people in more senior roles. When changes in the area manager took place BCC and the CQC were not always informed promptly of these changes. The constant changes in management and senior management has not helped in addressing the issues at the service or demonstrated good management and leadership.

Nursing staff we spoke with at the service were not clear on what their role was in ensuring that care staff were working towards the values of the provider. They were not aware of the current challenges amongst the staff team and had not been told by management of the home what the priorities were in relation to improving the standards of care at the service. Due to the lack of effective formal supervision, nurses were unclear of their role in providing leadership to the care staff. We observed that care and support provided by staff was not guided by good practice or effective management but more about what tasks needed to be done. Due to the high turnover of nursing staff and the high use of agency nursing staff, this had not helped in providing care staff with effective leadership and management.

The provider operates a system of internal audits in key areas of the care delivered at the home. These included audits in medication, infection control, care documentation, staff training and recruitment. These were planned to occur throughout the year and these were being completed by the management of the service. These audits were supported by monthly visits by senior management who carried out checks on the service; we noted that these audits were occurring. However, at our inspection in August 2014, we found the provider was non-compliant in five outcomes. Since our inspection in August 2014, we found sufficient improvements had not been made to improve the service for people who lived at the home. This lack of response and action to the concerns raised at previous inspections demonstrates inadequate management and leadership of the service.

The inspection team noticed a strong smell of urine throughout the home on both days of the inspection. Comments from relatives confirmed that this was normal. One relative told us "I expect you get used to the smell, going in to lots of care homes." We informed this relative that it is not usual or acceptable for a care home to smell in this way. The management of the home has informed us that they will be putting measures in place to improve the smell. However, this should have been picked up by the management of the home and dealt with effectively.

This was a breach of Regulation 10 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.

Prior to our inspection visit Buckinghamshire County Council had raised concerns about the service with the Chief Executive of the provider. The provider had implemented several measures which included changing the line manager arrangements for the service, so that the manager now reported directly to a senior manager. We spoke with this senior manager who told us that they were taking the following measures:

- Providing extra experienced care staff to work alongside the care staff to working at the service.
- An experienced manager to work with the night staff working at the home.
- Experienced nurses from the providers other services to work alongside nurses working in the service.
- The Head of dementia care for the provider had been brought in to assess the current level of dementia care at the service and to develop an action plan to improve this area.

The senior manager told us that they were taking personal ownership of driving improvements at the service and would ensure that improvements were made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **How the regulation was not being met: People were not always treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **How the regulation was not being met: People's consent was not always sought.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **How the regulation was not being met: People were not always protected from risk of harm.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **How the regulation was not being met: People who used the service could not be sure they were supported in a way which met their needs.**

The enforcement action we took:
We served the provider a warning notice due to a breach of regulation 9. We asked the provider to take appropriate action by 8 May 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **How the regulation was not being met: People who used the service could not be sure the provider undertook appropriate quality monitoring checks to ensure the quality of the service provision.**

The enforcement action we took:
We served the provider a warning notice due to a breach of regulation 10. We asked the provider to take appropriate action by 8 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **How the regulation was not being met: People were not supported against the risks associated with poor nutrition and hydration.**

The enforcement action we took:
We served the provider a warning notice due to a breach of regulation 10. We asked the provider to take appropriate action by 8 May 2015.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: People could not be sure their needs were met by adequate staffing levels.

The enforcement action we took:
We served the provider a warning notice due to a breach of regulation 10. We asked the provider to take appropriate action by 8 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: People who used the service could not be sure they were supported by staff who were appropriately inducted and trained.

The enforcement action we took:
We served the provider a warning notice due to a breach of regulation 23. We asked the provider to take appropriate action by 8 May 2015.