Quality Care Midlands Limited

Charnwood Hall Nursing Home

Inspection report

38 Charnwood Road
Shepshed
Loughborough
Leicestershire
LE12 9QF

Tel: 01509650717

Date of inspection visit:
14 April 2016
15 April 2016
03 May 2016

Date of publication:
22 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted an unannounced inspection on the 14 April 2016 and returned announced on 15 April and 3 May 2016.

Charnwood Hall providers nursing and residential care for older people. It is registered to accommodate up to 25 people, there were 19 people using the service on the day of our inspection.

The service had a registered manager. 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. The registered manager had been absent from the service for eight weeks prior to our inspection. They were not present on the first day of our inspection.

We identified that the provider was in breach of three of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 and one of the Regulations of the Care Quality Commissions (Registration) Regulations 2009. You can see at the end of this report the action we have asked them to take.

People told us they did not always feel safe. Not all staff were aware of how to report concerns about people's safety and how to report and escalate issues and incidents if required.

Risks relating to the environment and people's care needs were not always appropriately assessed. Where people were at risk due to their medical conditions it was not clear what measures should be taken to prevent harm. Not all staff were aware of the action they should take in the event of a fire or how to support people to evacuate safely. We identified issues relating to the cleanliness of the home.

There were not enough staff to keep people safe and to meet their needs. People were not always supported to take their medications as prescribed by their doctor. Systems to ensure that medicines were stored and administered safely were not in place.

People could not be sure that they would receive care from staff who had the knowledge and skills to carry out their roles and responsibilities. Staff had not received regular training and support to enable them to do their role. Staff did not feel supported.

The provider had not ensured that the requirements of the Mental Capacity Act 2005 (MCA) were being met. Proper consideration had not been given to whether people had the capacity to make decisions and to consent to their care. The registered manager had not applied to deprive people of their liberty in line with the MCA and Deprivation of Liberty Safeguards.

People were not always supported to have enough to eat and drink and maintain a balanced diet. We

identified that some people were at risk of dehydration or malnutrition but necessary steps to prevent this were not taken.

People were not always supported to maintain good health. Where risks to people's health had been identified appropriate measures had not always been put in place to manage the risks. People had access to health care professionals but the records regarding their health care needs were not always clearly maintained.

We received mixed feedback about whether staff were kind and caring. Most people told us that they were treated with dignity and respect but some people said that they were not.

People were not involved in making decisions about the care and treatment that they received. Care records were not person centred and did not provide enough detail for staff to be able to meet their needs. People were not supported to follow their interests.

People were not asked for feedback about how the service was run. The registered manager and the provider had not implemented systems to ensure the smooth running of the service. The provider had not acted promptly when they had been made aware of shortfalls by outside professionals. The provider had not ensured that suitable support was in place in the absence of the registered manager and had not notified the absence and interim management arrangements to the Care Quality Commission.

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 safe

People were not protected from the risk of harm. There were not enough staff to meet people's needs. Systems were not in place to ensure that people received their medicine safely. Staff were not clear on their role to report and escalate safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not effective

Staff had not received appropriate training and supervision to enable them to meet the requirements of their role. People were not protected from the risk of dehydration and malnutrition. The registered manager was not working in line with the Mental Capacity Act 2005

Is the service caring?

Requires Improvement

The service was not caring

People were not always treated with dignity and respect. Staff interactions with people were sometimes warm and friendly but often task led.

Is the service responsive?

Requires Improvement

The service was not responsive

People contributed to reviewing their care and were not involved in making decisions about the care they received. Care records were not person centred and did not provide enough detail for staff to be able to meet their needs. People were not supported to follow their interests.

People were not asked for feedback about how the service was run.

Is the service well-led?

Requires Improvement

The service was not well led

Systems were not in place to ensure the smooth running of the service. The provider had not acted promptly when they had been made aware of shortfalls by outside professionals. The provider had not ensured that suitable support was in place in the absence of the registered manager and had not notified the absence to the Care Quality Commission.

Charnwood Hall Nursing Home

Detailed findings

Background to this inspection

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

We conducted an inspection on the 14 and 15 April 2016 and returned on 3 May 2016. The first day of the inspection was unannounced.

The inspection team consisted of an inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spoke with seven people and three relatives of people who used the service.

We looked at the care plans and care records of six people who used the service at the time of our inspection. During our inspection we spoke with staff members employed by the service including the cook, a nurse, the person who oversaw maintenance and four care workers. We also spoke with the provider and the registered manager. The registered manager had been absent from the service for eight weeks prior to our inspection. They were not present on the first day of our inspection.
We looked at four staff recruitment files to see how the provider recruited and appointed staff. We also looked at records associated with the provider's monitoring of the quality of the service and evidence of staff training.

Before the inspection we reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted health and social care professionals who have dealings with the service to gain their views of how the service was run and the quality of the care and support provided by the service. We contacted the local authority and

Clinical Commissioning Group (CCG) who had funding responsibility for some of the people who were using the service.

Requires Improvement

Is the service safe?

Our findings

Not all people we spoke with felt safe. One person said, "I feel safer here. I wasn't safe at my old house". Another person said "I have seen nothing that worries me" However another person told us, "No, I don't feel safe. They don't carry out their promises." Relatives gave mixed views one said, "I feel my dad is safe here" but another said, "Mum is very distressed when they are rough with her and she is not believed."

Equipment was not checked to ensure that it was appropriate and safe to use. One staff member told us, "They are losing independence as we have no stand aid available so they have to be hoisted. Equipment is not maintained. We aren't provided with the equipment and resources to do our job well". Staff meeting records indicated that wheel chair checks should be carried out monthly. We saw the last check was made in July 2015. After our inspection the funding authority conducted their own inspection and identified that slings used to move people in hoists were damaged and could not be safely used.

We observed that the home environment was not safely maintained. One relative told us, "We have repeatedly asked for a lightbulb to be replaced in their room but it has not been dealt with. Things never get done" Another relative told us, "An exposed electrical point in their room which could be dangerous if mum stumbles and reaches out to grab something". We identified some uneven floor surfaces that could pose a trip hazard, doors that should have been locked to prevent risk to people, a window which required fixing and a concern regarding access to a fire exit. After our inspection the funding authority conducted a health and safety audit of the building and found a number of concerns regarding the safety of the home environment. The provider did not have appropriate systems in place to identify where health and safety risks were present and take appropriate action to reduce the risk. Since the inspection the provider has told us that they will address the issues regarding the physical environment.

The home was not clean. One relative told us, "Could do with a tidy up, it's disgusting in places". There were no cleaning rota's in place and the registered manager and provider did not routinely check the cleanliness of the building. The hall and lounge carpets were heavily stained. The provider told us that the carpets had been cleaned in the past few weeks however we saw that a rodent trap had not been moved when the cleaning had taken place. On checking all the bathrooms, toilets and sluice rooms we observed that there were no foot operated clinical waste bins within the home this is not in line with current infection control guidelines. We checked the medication room at the home and observed there were thirteen full sharps bins stored on the floor. We asked the nurse who was responsible for the removal of these bins why the bins had not been collected, but the nurse said that she was not sure. When we returned on the last day of our inspection the bins had been collected by an appropriate clinical waste disposal company. This meant that there were not systems in place to ensure that the premises and equipment were kept clean and systems implemented to take action when shortfalls were identified.
Some routine testing of equipment and services had been completed to ensure that they were safe. Where regular testing was required to prevent risk, such as water temperature testing these had not been taken appropriately in the absence of the registered manager. After our inspection the local authority conducted a health and safety audit and found that the water temperature in some sinks was hotter than would be considered safe and that the maintenance staff member did not have the appropriate equipment available

to complete accurate tests.

These matters constituted a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff to keep people safe. The registered manager did not have a system in place to formally assess the level of staff support required to keep people safe. Feedback from people about whether there were enough staff was mixed. One person told us, "If I want anything, they respond fairly quickly, usually within ten minutes." Another said "You have to wait a little sometimes but they do come, we aren't ignored". However a person using the service told us, "I feel safe, there is always someone nearby." One relative told us, "I have seen eight staff take their breaks together and had to step in and help clients as no-one is available. I have sat for 25 minutes when there have been no carers to see to clients because they are all at break together". One staff member told us, "Staffing levels are not enough when someone is ill or deteriorates and the night shift are at breaking point with a wandering patient who endangers herself and other service users." Another staff member said, "In the morning yes there are enough staff, but in the afternoon maybe not. Could do with more at night." We conducted an observation in the communal sitting area over a 45 minute time span. Although there were staff coming in and out of the room there was a total of 17 minutes when a member of staff was in attendance which was mostly made up of brief visits without interaction with people using the service Since our inspection the provider has increased the level of staffing at night at the request of the local authority.

People were not always supported to take their medications as prescribed by their doctor. We observed that the service had a medication policy in place. One person told us, "If I am in pain, I can call for painkillers anytime and all my tablets arrive on time" One relative told us, "Dad is much happier here. They have managed his medications marvellously and gone out of their way to stabilise his condition. He has gained weight nicely". We saw that medication administration record (MAR) charts were used to inform staff which medicine was required and this was then used to check and dispense the medicines.

We saw that there were no clear guidelines regarding how each person liked to take their medicines. Where people had allergies these were no recorded on MAR charts. One person required their medicines to be given to them covertly. Clear guidelines were not in place to support staff to do this safety and this had not been formal agreed to by the person's doctor. This meant people were at risk of not receiving their medicines as they wished and were at risk of receiving medicines that they were allergic to.

Medicines were not safely managed within the home. We identified concerns regarding the storage and disposal of medicines. Medicines were not routinely checked and appropriate action taken to monitor and prevent errors. A visiting health professional had identified where a person had regularly taken some medicines but not others. Staff had not picked this up and consulted the person's doctor for advice. Since our inspection the registered manager had arranged for that person's medicine to be reviewed by their doctor.

Action was not always taken to prevent the risk of further harm after an accident had occurred. Nursing staff where required to complete accident/incident forms. The registered manager reviewed these and took action to prevent further risk however the registered manager had been away from the service for at least eight weeks and accident and incident forms had not been reviewed whilst they were away. We saw that the forms were in a tray for the registered manager's attention when they returned to work.

People were not protected from the risk of harm. We looked six people's plans of care and found risk assessments had been completed on areas such as moving and handling, nutrition and skin care. We found

that risk assessments had not clearly identified what the risks were. Guidance for staff to be put in place to minimise the impact of these risks was not clear. On the first day of our inspection we asked three staff members how many people required regularly turning in order to prevent them developing pressure related issues with their skin. All three replied that at that time only one person required turning. We asked the nurse in charge the same question and they told us that two people required turning regularly. Where people were at risk of dehydration or malnutrition appropriate guidance and monitoring had not been implemented.

Risk associated with the environment, tasks carried out and equipment used had not been regularly assessed to identify hazards and measures had been in place to prevent harm. We found that the risks associated with activities within the kitchen environment had been assessed in 2004 but had not been reviewed since. Risks associated with slips, trips and falls had not been formally assessed and measures implemented to reduce the likelihood of harm. Some people were supported in bed with bed rails to prevent falls. Regular checking of bed rails is required to ensure that they are safe. These checks had not been made. A visit by health professionals in March 2016 had identified this as a concern and highlighted it to the provider but they had not taken action. The registered manager instructed the nurse to complete these checks on the day of our visit when the concern was raised with them.

People were not protected from the risk of fire. The help that people would need if there was a fire had been formally assessed however these had not all been reviewed regularly. Not all staff were aware of their responsibility to provide the appropriate help. Fire safety checks had been carried out but an external agency found that issues had not been identified during the course of these checks.

These matters constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a recruitment policy in place which the registered manager followed. This ensured that all relevant checks were carried out on staff members prior to them starting work. However we looked at the recruitment files for four staff members and found that appropriate references had not always been sought. Records indicated that not all the required pre-employment checks had not been carried out before staff had commenced work. The registered manager told us that the necessary checks had been made but the paperwork had been damaged therefore further checks were taken after some staff had been employed. We accepted their explanation but requested they review how they request references for new staff in the future.

We saw that there was a policy in place that provided staff, visitors and people using the service with details of how to report safeguarding concerns. Not all staff were aware of this policy or how to report and escalate if required. They told us that they felt able to report concerns. One said "I would report it to the manager." The registered manager was aware of their duty to report and respond to safeguarding situations however the provider or nursing staff were not fully aware of their responsibility in the absence of the registered manager. At the time of our inspection we became aware of a concern that had not been reported to the local safeguarding team. Staff had not recognised this and other indicators that people may not be safe

Requires Improvement

Is the service effective?

Our findings

People could not be sure that they would receive care from staff who had the knowledge and skills to carry out their roles and responsibilities. Staff training records indicated that staff had not received mandatory training that was in date. We asked the registered manager if the training matrix was up to date. She said it was not and that she would update it however updated records indicated that staff were in need of additional or refresher mandatory training. This included training that would ensure that people with mobility issues were supported in line with their requirements. After the inspection we were told that staff had been enrolled on a number of training courses to update their skills.

The training and support that staff received when they first came to work at the service was not sufficient for them to meet the needs of people. The registered manager told us that staff were required to complete role specific training as well as formal training courses. Records indicated that some but not all staff had completed these. The registered manager told us that staff were required to complete induction packs so that they could demonstrate their understanding and skill. These were not always kept on file. The registered manager later produced induction packs for these staff We saw that the packs had not been completed or checked over to see if staff had understood the content. We also saw that the kitchen assistant had not received appropriate food hygiene training.

The registered manager could not be sure that staff were competent to complete their role. Staff had not identified when the equipment that they needed to use to help people transfer safely was worn and no longer safe to use. We saw that some nursing staff had received competency checks regarding their practice and understanding of their role but that these had not been adequately completed. We saw two examples of competency checks but these were not dated. A nurse on duty had not received any training since starting work at the service over a year ago. Competency checks around medication administration or moving and handling were not available. We did records relating to competency checks for care staff around supporting people with oral hygiene and eating. These were dated April 2014 and took the form of a group discussion rather than direct observations. After our inspection the registered manager told us that they intended to implement competency checks for all staff and record them in documentation.

Staff did not feel adequately supported. One staff member said, "I haven't had an appraisal since I've been here in ten years." We reviewed this staff member's file which seemed to support this. Some staff have not received supervisions since April 2014. We saw some group supervisions had been completed. Some staff felt that their care experience alone prior to Charnwood had enabled them to be qualified to complete their role. The provider does not complete formal supervision with the registered manager.

The service occasionally employs agency staff. There were not records to demonstrate that these staff were suitable or had received an appropriate induction. The provider had not ensured that suitable senior cover was in place while the registered manager was off sick.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that people were not always being supported in line with the Act. The service did not have a policy to guide staff in line with MCA. The Act requires that people's capacity to make decisions is assessed on a decision by decision basis. We found that where there was a suspicion that people lacked mental capacity assessments were not carried out. The registered manager had requested a DoLs authorisation for one person. We checked a DOLS authorisation of a person and all relevant paperwork was included and up to date. We observed that there was recommendations made on the authorisation but did not see evidence of these recommendations recorded in the support plan. We asked staff about the recommendations. We found that staff at all levels within the home did not have a clear understanding of their responsibility under the MCA. Training records indicated that not all staff had received training about the MCA and where they had they had many not received refresher training since 2013. The registered manager told us that training had been booked for all staff to attend over the coming months. Since our inspection the registered manager has made further DoLS referrals.

Where people had capacity to consent to their care it was not always clear if this had been sought. Some people had signed consent to care forms however these had not been reviewed with people to check if they were still in agreement. We saw that one person had not formally been asked their consent for the service to provide care since 2011. We saw that the registered manager or nurse had signed some consent forms on behalf of people. We asked a staff member if they thought a person with bed rails on their bed had the ability to give informed consent for their use. The staff member said they thought they did not. This would mean that the person was being unlawfully restrained.

We observed the lunch time routine. The food was of a high standard and the feedback regarding meals was positive. One person told us, "Food is good. I always get extras and there are alternatives offered. We are offered plenty of drinks." One relative told us, "The food is very good and all home cooked. Mum has gained weight. Some days there are choices but there are no snacks outside of mealtimes. They sometimes have tea and biscuits but some days they don't come round with the trolley. It can be a bit regimental." We saw that there was not a choice of an alternative meal. The cook informed us that they were aware of people's preferences and would cater for these. We observed lunch being served and the atmosphere was very pleasant and considered. People were offered four choices of drink and offered salt for their meals if they wanted it. There were alternatives offered with the dessert. One client asked for a smaller portion and this was immediately responded to. Food was cut up appropriately for those who needed it and protective tabards given to those who needed them. We observed staff showing respect for the independence of the service users with no hurry to finish their food and no inappropriate staff help. Individual dietary needs were catered for such as soft diets and staff were aware of how to provide these. Staff had a good understanding of individual's preferences and needs.

People were not always supported to have enough to eat and drink and maintain a balanced diet. We identified that some people were at risk of dehydration or malnutrition but necessary steps to prevent this

were not taken. Some people did not have their fluid or food intakes routinely recorded, despite them being identified as at risk. However, there were some people that did have their intakes recorded. We checked several of these people's intake charts and found them to be inconsistently filled in. Entries were missing and we for that at times the last recorded fluid intake was at noon until the next day. We identified that there were times when a person's fluid chart would indicate that they had not had enough fluid intake throughout the day but we were unable to see that any action was taken. We asked a care worker where client's food and fluid intake charts were kept. We were told "we put it in the book if they don't eat or drink and if this goes on for three days we pass it on".

People were not always supported to maintain good health. Where risks to people's health had been identified appropriate measures had not always been put in place to reduce the risks. People had access to health care services and received on-going medical support. We were informed by the nurse that a doctor visits the home on a weekly basis, the optician visits twice a month and the podiatrist visits monthly. These visits were recorded in the support plans however it was not always clear what the outcome of these visits had been or whether further action was be taken to promote people's health and wellbeing. We saw that one person had been seen by their doctor on a number of occasions for an on-going health care need. Records were not clear as to when some visits had taken place as the date recorded was the person's date of birth rather than the date they saw their doctor. The doctor had made clear recommendations for staff to follow to help manager their condition but this had not been reflected in their care plan. The recommendations required close monitoring of the persons fluid intake but this had not been implemented.

Requires Improvement

Is the service caring?

Our findings

People did not always feel that they were treated with kindness and compassion. Feedback was mixed. One person told us, "I'm very well cared for here. I feel they respect me and anything I ask for is dealt with. I feel things are improving." However one person told us, "Things have changed, it's not as good and I am not as happy now." Another person said "Some staff are very nice but it varies. Some are very good but some don't care and shouldn't be employed. I shouldn't grumble about these things but some care isn't good, the majority are good though". One relative told us, "A couple of the staff are abrupt and rough with mum. We dread those days. We know which staff are rough and which aren't. They don't treat her with dignity." One staff member told us, "A couple of residents have said that some staff could be nicer."

On one occasion we observed two staff enter a lounge and a person speak to them. Neither of the staff made eye contact or responded to the person. However we did witness some warm interactions between people and staff particularly at meal times. Staff we spoke with all spoke with passion about provision of good quality of care and had a good understanding of what constitutes this. One staff member told us, "[people's] care needs are put first." But they also told us that "Some staff can be less attentive or more abrupt."

People's dignity and privacy was not always promoted by the provider. One person said, "They respect my privacy, I am not forced into doing things. I am a bit of a loner." A second person said, "My privacy is respected. I don't go into the lounge." However one person told us, "A lady wanders and keeps walking into my room even at night." A relative told us, "We are regular visitors and witness a consistent lack of empathy and compassion. They are rushed and dismissive of mum's needs". We saw an example of staff not respecting a person's dignity during a lunch time when a nurse administered an injection to someone whilst they were eating their meal in a crowded dining room.
We found that none of the three downstairs toilet doors were able to be locked. We raised this with the provider who told us that they would arrange for locks to be fitted. When we returned on 3 May we found that locks had been fitted but they were not working. This meant that there was not a consistent culture that respected people's dignity and privacy.

Staff told us that people were free to make choices about when they wanted to get up or do things but one person did not agree. They said, "I can stay in bed if I am poorly but have to get up when they come as I make a lot of work for them due to my condition." We saw that people were not always able to make choices about things that were important to them. We saw that there was a bath or shower rota. Staff told us that each person was allocated a day when they could have a bath or a shower. There was no indication within peoples care plans if people had been asked their views on this.

Relatives told us that they felt welcome to visit at any time and that there were no restrictions. We saw that some people were supported to maintain relationships that were important to them. However, where people were identified as being at risk of social isolation no action was identified as to be taken to reduce the risk of them becoming isolated.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. We saw that people's needs had been assessed and care plans had been put in place .We found that these plans were not always detailed enough to reflect the level of support that people needed and their preferences were not made clear. For example, care plans did not state the level of support people would require in order for them to attend to their personal care needs. Support staff did not access the care plans or use them as a guide of how to support people.

People had not contributed to the planning of their care. The registered manager had completed pre-admission assessments with people but the information gathered had not translated into the information within people's care plans. For example, a preadmission assessment indicated that one person required full support with personal care however their care plan stated they only needed support when they showered due to the risk of them falling.

There was a risk that important information about people's changing needs would not be communicated to staff supporting them. We observed that a handover took place between each shift. During handover each person's progress and well-being was discussed. The nurse recorded any issues on handover sheets but these were not kept. The nurse informed us that they are ripped up and thrown away. This meant that information relating to clients daily events including medical and health information could not be tracked to enable staff to make comparisons about health improvements or deteriorations. We were told that a communication book was used to communicate to staff, however we checked this book and this was not being used on a regular daily basis. One staff member replied "What communication book?" when we asked them about it. This meant that any member of staff who was not present at the handover would not be aware of people's changing needs.

People were not supported to follow their interests. One person told us, "In the good weather we go out for a walk" and " the Brownies are coming to visit and we sometimes play bingo." There provider does not employ a member of staff to provide activities to people. We were told that care staff were expected to provide activities. One staff member said, "They used to pay for activities with a coordinator but it stopped and has to be done by care staff during the shift. We don't have time."

On our arrival we saw the activities board which stated that the only activity for the week was a visit from the hair dresser. One relative said "There is bingo at times but the piano has gone. They loved that. Music is played, which is a nice alternative to the television. We came to the Christmas Nativity and it was lovely, really good fun." During a 45 minute observation period in the lounge, we observed long periods when staff were not present and minimal interaction. The room had eight people present and a television was on. Otherwise there was no stimulation or activity and people sat or slept. When staff entered the room they were task orientated and rarely interacted with the people who were awake. One staff member told us, "There is hair dressing weekly, but the carers don't get time to arrange or do activities, some of the clients aren't bothered about doing anything. They like to rest." Another staff member said, "They need more stimulation. Some people have said that they are bored." The registered manager told us that activities

records should be maintained to record what activities people had been offered and what activities they had taken part in. We reviewed these records and found that there had been no entry since 21 November 2015. Concerns regarding lack of activity for people had been raised by an external professional in March 2016 however the provider had not taken action to address this.

The provider did not routinely listen and learn from people's experiences, to improve the quality of the service. One person told us, "I have never heard of any meetings for residents." One relative said, "There used to be a suggestions box but this disappeared a while ago. Issues are referred by the staff to the manager. There are no satisfaction surveys. Our views aren't asked." They told that "The staff are uncommunicative."

People felt that they could make a complaint if they needed to. One person said, "I have not needed to complaint but if I did I would go to the office." They also said "They know what needs doing and they do it. The lines of communication are good" One relative we spoke with told us that they had not made a formal complaint but had had an informal meeting with the manager, which had resolved their concern. We saw that the complaints procedure was on display in the foyer. The provider told us that they had not received any formal complaints.

Requires Improvement

Is the service well-led?

Our findings

Providers are required to inform the Care Quality Commission of significant events that happen in the home or changes to the management of the home. The provider had failed to inform us that the registered manager was away from the service for a period of over 28 days and what arrangements had been made for the management of the carrying on of the regulated activities during the period of their absence. Many of the shortfalls we identified in this inspection were associated with the absence of the registered manager and suitable alternative arrangements during their absence.

This constituted a breach of Regulation 14 of the Care Quality Commissions (Registration) Regulations 2009.

The provider had failed to take steps to ensure appropriate leadership cover was in place while the registered manager was away from the service. We asked who was in charge during the absence of the registered manager and we were told that the provider was in charge. However the provider often referred to the nurse in charge and was not able to demonstrate that they had an understanding of the day to day running of the home or their responsibilities with regard to ensuring that care was provided in line with the Health and Social Care Act 2008 (Regulated activities). A staff member told us, "[provider] is not qualified." We asked the provider about how the service was meeting the requirement of the MCA. The provider was not aware of the legislation.

The provider had failed to take action when concerns regarding health and safety or care practices had been brought to their attention. We were aware that a health professional had brought 42 separate concerns to the provider's attention in March 2016 however none of these had been addressed when we conducted our inspection in April. The provider told us that they planned to wait until the registered manager returned to post to begin addressing the issues. This meant there was no leadership on those issues during the period the registered manager was away. We raised concerns regarding health and safety on the first day of our inspection. Some of these had not been addressed when we returned on the last day of our visit.

The registered manager completed monthly audits of medication systems, falls and health and safety systems within the home. The provider had not considered the need to ensure that audits and health and safety checks had taken place in the absence of the registered manager. Some routine audits did not take place. These included environmental audits and call bell response times. The provider had not conducted regular checks to ensure that systems were in place and were working appropriately.

These matters, along with concerns that we found around people's health care records and systems in place to monitor people's health, constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people using the service were not clear on who the registered manager was. One person said, "I am not sure who the manager is, except maybe the navy uniforms, who are always willing to help." Relatives knew who the registered manager was and felt that they could contact them if they needed to. A health professional told us, "[registered manager] has always been very helpful and willing to work with us."

Staff did not feel that they were motivated or supported by the registered manager or the provider.
A staff member said "There is no support from management." They told us that staff morale was low. They told us that they would address concerns with the nurse rather than the manager. One person told us, "I have no confidence that the manager would know what to do." We saw that staff meetings took place. During these the registered manager informed the staff team of any changes, new systems of working and cleaning duties. One staff member told us that if there were not present at the meetings, due to holiday or sickness then they did not receive the minutes of those meetings.

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 14 Registration Regulations 2009 Notifications – notices of absence The provider had not notified the Care Quality Commission of the absence of the registered manager for a continuous period of 28 days or more. and what arrangements had been made for the management of the carrying on of the regulated activities during the period of their absence.

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 safe care and treatment for people

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured that the premises and equipment used were clean, secure and properly maintained.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that records relating to the care and treatment of each person were fit for purpose, assessable to staff as necessary for them to meet the needs of people and keep them safe. The provider had not ensured that their audit and governance systems were effective.

The enforcement action we took:

Issue warning notice