Laudcare Limited

Sunnymead Manor

Inspection report

575-579 Southmead Road
Southmead
Bristol
BS10 5NL

Tel: 01179791212

Date of inspection visit:
11 March 2016

Date of publication:
10 May 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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 11 March 2016 and was unannounced. The last full inspection took place on 2 February 2015 and, at that time, two breaches of the Health and Social Care (Regulated Activities) Regulations 2014 were found in relation to safe care and treatment and good governance. These breaches were followed up as part of our inspection.

Sunnymead is registered to provide personal care and nursing care for up to 76 people. The service has two units, Hollies and Poplars. Poplars unit provides care and support to people living with dementia. At the time of our inspection there were 36 people living in the service.

There was no registered manager in place on the day 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. The deputy manager had the current responsibility of running the service.

In February 2015 we found that people's care records were not always maintained accurately and completely to ensure full information was available. At this inspection the provider had not made sufficient improvements.

In February 2015 people's medicines were not always managed and administered safely. At this inspection the provider had not made sufficient improvements.

People were not always safe as there were not always sufficient numbers of suitably qualified and skilled staff to support their needs. Staffing levels were not maintained in accordance with the level determined by the provider's dependency tool.

The provider had inconsistent arrangements in place for reporting and reviewing incidents and accidents. Records showed some incidents were clearly audited and actions were followed up and support plans adjusted accordingly. Other incidents were processed but there was not a clear audit trail of the investigation and the outcome.

Staff were not consistently supported through an effective training and supervision programme.

Staff demonstrated a basic understanding of how to recognise and report abuse. Although the majority of staff confirmed they had received safeguarding training, not all were able to describe what abuse was or how they would report it.

The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. Not all records were completed accurately to manage and

ensure that people's on-going needs were met and risks mitigated.

People's nutrition and hydration needs were not consistently met.

People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005. This provides a legal framework to protect people who are unable to make certain decisions themselves.

The service was not consistently responsive to a person's needs. We found that the care plans did not reflect people's individualised needs. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement.

Since the previous inspection conducted in February 2015 the provider had failed to fully implement the actions in their plan to ensure they were no longer acting in breach of the regulations. As well as not fully implementing the stated actions in the plan we found that the number of breaches of regulations has increased.

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. This resulted in poor practice across the service.

The majority of staff demonstrated kind and compassionate behaviour towards the people they were caring for.

Records showed a range of checks had been carried out on staff to determine their suitability for the work. For example, references had been obtained and information received from the Disclosure and Barring Service (DBS).

People were cared for in a safe, clean and hygienic environment. The home was free of odours and daily cleaning schedules were completed throughout the building.

People had their physical health and mental health needs monitored. The care plans showed people had access to healthcare professionals according to their needs. We noted that people had access to their GP, speech and language therapists, tissue viability nurses and the dementia well-being team.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

People were encouraged to provide feedback on their experience of the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not consistently managed safely.

Staffing levels were not sufficient to support people safely.

Safe recruitment processes were in place that safeguarded people living in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutrition and hydration needs were not met.

Deprivation of Liberty Safeguards (DoLS) applications had not been made for people that required them.

Staff were not supported through an effective training and supervision programme.

Is the service caring?

Requires Improvement

The service was not always caring.

People sat for long periods of time without any social interaction or stimulation.

The majority of staff demonstrated kind and compassionate behaviour towards the people they were caring for.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not consistently responsive to a person's needs.

Care plans were not consistently written in conjunction with

people or their representative and people had not signed their care plans to indicate their agreement.

A complaints procedure was in place and the deputy manager responded to people's complaints in line with the organisation's policy.

Is the service well-led?

Inadequate

The service was not always well-led.

Since the previous inspection conducted in February 2015 the provider had failed to fully implement the actions in their plan to ensure they were no longer acting in breach of the regulations. This inspection identified that the numbers of breaches of regulations has increased.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided.

People were encouraged to provide feedback on their experience of the service.

Sunnymead Manor

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.

This inspection took place on 11 March 2016 and was unannounced. The inspection was undertaken by two inspectors.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who used the service were able to tell us of their experience of living in the home. For those who were unable we made detailed observations of their interactions with staff in communal areas.

We spoke with six people that used the service, two relatives and eight members of staff. We also spoke with the deputy manager, the quality support manager and the regional manager.

We reviewed the care plans and associated records of six people who used the service. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

In February 2015 the service did not manage medicines safely. The provider sent us an action plan telling us what they were going to do in order to meet the regulation.

During this inspection we found insufficient improvements had been made. Medicines were not managed safely. The provider did not adhere to their own policy regarding the administration of covert medication. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the individual is unknowingly taking medication.

The provider's covert medicines policy stated that a best interest's declaration form should be completed alongside a mental capacity assessment. The decision to administer covertly should only be reached after assessment of the care needs of the person and there must be a multi-disciplinary discussion involving the GP, pharmacist and relatives. The method of administration must be agreed with the pharmacist. Where covert medicines were being administered there was no evidence of a mental capacity assessment having been completed, no evidence of a best interests meeting, and no evidence of pharmacist involvement. The person's medicines were being crushed, but there was nothing documented by the pharmacist to confirm that the medicines mode of action would not be compromised by doing this. The provider's policy stated that "If medication is to be crushed or its form altered, this must be guided by pharmacist instruction". The staff member proceeded to crush the person's medicines and add them to a beaker of fluid for them to drink.

Where people had been prescribed creams or lotions there were Topical Medicines Administration Records (TMAR) in place. However, these provided limited information to the staff applying the creams, and had not been signed by staff to indicate they had been applied. For example, we looked at six TMAR charts. None of these had been signed during March 2016. The Care Home Assistant Practitioner (CHAP) confirmed we were looking at the correct charts. The charts for February 2016 had been inconsistently completed; one person had been prescribed a cream to be applied four times a day. The chart had not been signed since 22 February 2016. During February, it had only been signed as applied on eight occasions and never four times a day. Another person had been prescribed a cream twice a day. During February 2016, the chart had only been signed on four occasions and only once a day. This meant there was a risk that people did not receive their topical medicines as prescribed.

All of the Medicines Administration Records (MAR) we looked at were signed and up to date. MAR charts contained photographs of people but these had not all been dated. It was unclear how staff would know when they needed to be updated in order to ensure a true likeness of people. This is of particular relevance because the home used agency staff to fill vacant shifts and they were administering medicines to people. There was a risk that staff might not always be able to identify people easily when administering medicines.

Medicines were stored safely. Bottles of liquids had been dated when opened and where necessary items were stored in a medicines fridge. To ensure medicines were stored at the correct temperature the fridge

temperature had been monitored daily.

The service undertook a weekly medication TRaCA (audit) and we saw the records from 12 February and 07 March 2016. None of the issues of concern identified during our inspection had been identified by their own internal processes. An audit conducted by an external pharmacist on 30 June 2015 raised concerns regarding their covert medicines practice and this had not been addressed by the service.

This meant there continues to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that that people were not always safe, as there were not always sufficient numbers staff to support their needs. Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. We viewed the staffing rota from the 7 March to 13 March 2016 (as this was the only copy made available). The rota demonstrated that unexpected absences such as staff sickness were not covered and the remaining staff on shift had to cover for the absent staff. Staffing levels were not maintained in accordance with the level determined by the provider's dependency tool.

Staff gave mixed responses in relation to the staffing levels. Some staff felt there were enough on duty to meet people's needs, whilst others felt there were not enough. Staff comments included "Another person on duty would give us more time one to one with people. That would enable us to make residents feel this is their home rather than a care home"; "We are very task focussed. We have so many checks to do, that it sometimes feels a bit institutionalised" and; "We cannot use agency staff and the problem is that there are not enough staff. We try to do our best. I would send my relative here but not at the moment as we need more staff." Staff did not appear to be rushed during the inspection. Call bells were answered swiftly, but there were long periods of time where people were sat with no interaction. There was a lack of staff presence in communal areas. On one occasion a person was calling out repeatedly and sounded distressed from the communal area. Nobody went to their assistance. We went to check they were safe and asked if they would like us to call for assistance, which we did on their behalf. We went to find a member of staff to deal with their request.

The service has recently undertaken a recruitment drive current and had appointed two unit manager's. The service uses agency nurses but they do not currently use agency staff to cover care staff unexpected absences. On the day of our inspection a member of the care staff and a kitchen assistant called in sick and their absence was not covered.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been undertaken in relation to maintaining people's safety. These had been completed for risks associated with skin breakdown and nutrition for example and these had been reviewed monthly. One person had been risk assessed in relation to their dietary choices. The person frequently chose to eat and drink food which was not recommended for someone with their medical condition and the assessment showed that the person had been involved in the risk assessment. However risks associated with restrictions to people's freedom, choice and control had not always been assessed. For example, several people had bed rails in situ but there were no risk assessments in place in relation to their use.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had inconsistent arrangements in place for reporting and reviewing incidents and accidents. In most cases the deputy manager reviewed all incidents on a monthly basis to identify any particular trends or lessons to be learnt. Records showed some incidents were clearly audited and any actions were followed up and support plans adjusted accordingly. For example where people had been assessed as being at high risk of falling, the care plans contained staff instructions on how to enable activity and minimise risk. Other incidents were processed but there was not a clear audit trail of the investigation and the outcome. An example included two cases of unexplained bruising. The incidents were recorded on the person's support plan and processed through their internal incidents recording system. However, the incident records did not identify the start date of the investigation, any actions taken or lessons learned.

Staff demonstrated a basic understanding of how to recognise and report abuse. Although the majority of staff confirmed they had received safeguarding training, not all were able to describe what abuse was or how they would report it. One staff member described multiple things they would do before considering reporting an incident and others needed considerable prompting from us before confirming they would report concerns to the manager. The majority of staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice in the workplace.

Records showed a range of checks had been carried out on staff to determine their suitability for the work. For example, references had been obtained and information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults. Other checks had been made in order to confirm an applicant's identity and their employment history.

People were cared for in a safe, clean and hygienic environment. The home was free of odours and daily cleaning schedules were completed throughout the building. Staff wore personal protective clothing when required. We did advise the service that soap was not available in one bathroom and toiletries should not be stored together. The risk of sharing toiletries increased the risk of cross infection. The service agreed to take these issues forward with immediate effect.

Requires Improvement

Is the service effective?

Our findings

In February 2015 people's records were not always maintained accurately to ensure full information was available The provider sent us an action plan telling us what they were going to do in order to meet the regulation.

During this inspection we found insufficient improvements had been made. The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. Not all records were completed to manage and ensure that people's on-going needs were met and risks mitigated.

Some positioning charts were not consistently recorded to demonstrate when people had been repositioned in line with their assessed needs. An example of this included one person who had been assessed as high risk of pressure sores and had a care plan in place stating that two hourly position changes were required. On 9 March 2016, staff had documented the person was on their back at 07.10hrs but they had declined to move at 15.47, 17.29 and 19.30. On 10 March 2016 the person was noted as being on their left side at 09.15 and on their back at 11.00. There were no other entries for the day. On the day of the inspection (11 March 2016) no entries were recorded. This meant that despite risks being identified, people were not always protected and suitable care to meet their needs was not always adequately managed.

The provider failed to implement the actions stipulated in their action plan. The plan stated; "Team leaders to spot check re-positioning charts through the day and all charts to be signed off at the end of the shift by Team Leaders. Any discrepancies to be reported to the registered nurse on shift." Staff members failed to follow this protocol.

Some fluid charts were incomplete. Therefore staff did not have the accurate records of people's nutritional intake. Charts had not always been filled in, daily targets had not been noted and the totals had not been recorded on a daily basis. Staff knew why people were having their intake monitored but the charts were not consistently completed. For example one person was having their fluid intake and output monitored, but there was nothing documented for 9 March 2016 and 10 March 2016. This meant there was a risk that people might not receive enough to drink, but that staff would be unable to identify this or escalate any concerns.

The provider's action plan stated that team leaders would spot check fluid charts throughout the day and document. All charts were meant to be signed off at the end of the shift by the team leader and any discrepancies needed to be noted to the nurse on shift. The service failed to effectively implement their plan.

There continues to be a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005. This provides a legal framework to protect people who are unable to make certain decisions themselves. In some people's

support plans we did not see information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for where needed. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. Applications had not in all cases been made to the local authority where people were being deprived of their liberty.

Consent to care was not sought in line with legislation and guidance. Staff did not understand the requirements of the MCA. The training matrix highlighted that only 47% of staff received training on the MCA and 39% of staff received DoLS training. The Care Home Assistant Practitioner (CHAP) confirmed that a number of people did not have a completed mental capacity assessment in their support plan. This was evident from the viewed files. In the Hollies unit no-one had a DoLS authorisation in place, despite being unable to leave the building. We heard one person ask a member of staff to open the door and let them out; an authorisation should have been applied for where people's movements are being restricted. We viewed information from the local authority DoLS team which confirmed that the service was required to process a number of DoLS applications for consideration.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not consistently supported through an effective training and supervision programme. Staff we spoke told us they had not received regular supervisions. This position was reflected in the staff records. Staff confirmed that regular supervisions had not been held. One member of staff told us; "It's really hard without a registered manager, we need help." The lack of supervision meant that staff did not receive effective support on an on-going basis and training needs may not have been acted upon. The provider failed to adhere to its supervision policy which stated that; "Supervision shall take place every eight weeks or six times per year." The deputy manager has produced a matrix with the view that a regular supervision programme will be introduced for all staff members.

New staff undertook a period of induction and the provider's mandatory training before starting to care for people on their own. Staff told us about the training they had received but some modules of their training were out of date; this covered a variety of subjects such as basic life support and moving and handling theory. The training records demonstrated that staff mandatory training was out-of-date and required up-dating. The most recent training matrix identified that training for mandatory e-learning sessions was 47% against the provider's target of 95%. Some staff we spoke with in the dementia unit told us that they had not received formal dementia training. This position was reflected in the staff training records. One staff member said "Having lots of different managers has impacted on training for staff. I think staff are very dedicated, but not as skilled as they should be." Some staff had recently received dysphasia and textured modified training. Continence training has also been booked for staff to attend.

This was in breach Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

People's nutrition and hydration needs were not consistently met. When people had been assessed as having complex needs in relation to nutrition, external advice and support was generally sought. We did note one exception when a person was referred to the speech and language therapy (SALT) team following a choking risk assessment. The care plan showed that the referral had been made on 25 November 2015, and chased up on 01/12/2015, but there was nothing within the plan to demonstrate if the person had been seen by the SALT team or if the referral had been chased again.

People were offered a choice of a main meal and pudding and they described the food as "good" and "very nice. The food looked appetising and the components of pureed meals had been pureed separately. The dining room tables were laid and people had access to different drinks. People were offered sauces to accompany their meal.

People had their physical health and mental health needs monitored. The care plans showed people had access to healthcare professionals according to their needs and the plans contained written entries from visiting health professionals. We noted that people had access to their GP, speech and language therapists, tissue viability nurses and the dementia well-being team.

Requires Improvement

Is the service caring?

Our findings

People sat for long periods of time without any social interaction or stimulation. There was no regular staff presence in communal areas of the home in the event that service users need to get staff attention for support. Staff spent a lot of time in the office completing paperwork, rather than spending time out on the floor engaging with people. We observed people sitting in the foyer being passed by staff without acknowledging or chatting to them.

The majority of staff demonstrated kind and compassionate behaviour towards the people they were caring for. Most of the staff on duty knew people well. One member of staff told us; "Dementia people are in need of continuity of care. We know the residents and they know our faces." Comments from people and relatives included; "The staff are great and I get on with them well. They take note of people's needs and never leave them distressed." and; "The staff interact well. They're quite lively and jolly. They're caring and loving towards the residents."

During the lunchtime service interactions between staff and people were variable. In some cases staff were providing full explanations and offering choices of food, others were not offered choices. Some staff were encouraging people to eat and chatting about the food and having a laugh with the person. In other cases there was limited interaction. Staff appeared focussed on the task of assisting the person to eat rather than engaging with them.

Some people ate lunch in the dining room; others had lunch in their rooms. We also noted that one person who was eating their lunch in bed had their meal placed on their bedside table adjacent to a bottle of urine. This was inconsiderate and did not promote an enjoyable eating experience. We observed a member of staff approaching one person with an apron to protect their clothing. They did not ask the person if they wanted to wear the apron; they put it on and said "Alright?"

Within people's care plans there was a section for end of life planning. This planning enables people's preferences and choices to be taken into consideration while they are still able to communicate them and for those that matter to them to be involved. However, the end of life plans we looked at had not been completed. Although resuscitation decisions had been recorded, there was no other detail available. This lack of information meant that staff may not know how to manage, respect and follow people's choices when the time arose.

People's privacy and dignity was respected. We regularly observed staff knocking on the door before entering people's bedrooms. We heard the majority of speaking with people in a respectful and friendly way.

Requires Improvement

Is the service responsive?

Our findings

The service was not consistently responsive to a person's needs. We found that the care plans did not reflect people's individualised needs. Care plans were not consistently written in conjunction with people or their representative and people had not signed their care plans to indicate their agreement. One relative told us that they had been involved with their relative's pre-admission assessment to the service but they had not been involved in any meetings since April 2015. They told us; "They do contact me if she's not well or needs stuff."

One person's records contained statements regarding their challenging behaviour during personal care and pad changes. The support plan described the challenging behaviour and the potential triggers. It did not identify how to manage the behaviour when personal care was being given. The care plan gave general advice to staff to be patient and to give reassurance, but did not guide staff on what specific techniques of positive behaviour management to use. ABC charts had not been completed. An ABC chart is an observational tool that allows a service to record information about a particular behaviour. The aim of using an ABC chart is to better understand what the behaviour is communicating and incorporate strategies on how best to deal with challenging behaviour. There was no evidence that consistent management strategies had been implemented, monitored or effectively reviewed.

Care plans were of an inconsistent quality and provided variable detail for staff to follow. Although some plans provided the detail, the evaluation of the plans showed that staff had not always followed them. One person had moved into the service during September 2015 with a grade four pressure sore. A referral had been made to the local tissue viability nurse and the person was being seen regularly by the wound care service. The care plan detailed the type of dressing to be used, the frequency of wound care and photographs to document the status of the wound. The photographs were of a varied quality; some were blurred and it was difficult to assess the wound. Despite clear instructions provided we were told that agency staff failed to follow the instructions. It was clear that the wound had required more frequent dressing changes because of being dressed incorrectly by agency staff. Owing to staff not following the instructions staff had documented on 1 March 2016 'Wound appears deeper' and on 3 March 2016 'Wound appears to have increased in size.' Notes from the wound care team on 10/03/2016 stated "Wound reviewed – very slow to heal.'

As part of the person's care plan there was guidance for staff on how to position the person to relieve pressure and prevent further skin breakdown. During staff handover, staff were informed to position the person from left side to right side only, but this level of detail was not written in the plan; the plan stated "2 hourly repositioning". However, the position charts showed that on 10/03/2016 from 07.20hrs to 09.20 the person was on their back. The same position was recorded from 13.09 to 15.08 and 17.21 to 19.41 and for the following day from 01.05 to 09.10.

Another person had been assessed as being at high risk of pressure sores. Their care plan informed staff they should have their position changed every two hours. However, the position change chart did not specify how frequently the person should be assisted to move. On 6 March 2016 the chart showed the person was

sat in their chair from 09.10 to 15.20 – 6 hours in total. On 10 March 2016 the chart showed the person was sat in their chair from 11.00 to 19.40 – a total of 8 hours. On the day of the inspection the person was observed sitting in the same position in their chair from 08.30 to 15.00. Staff did ask the person if they would like to rest on the bed for a while but the person declined. However, if the person had declined to be moved previously, this refusal had not been documented on the position chart, although we did see other charts where refusal had been noted by staff. Staff also did not seem to consider the option to assist the person to stand for a short period of time to relieve the pressure. This discrepancy meant there was a risk that people were not always receiving care that was responsive to their needs. Staff said they knew why people needed to have their positions changed, but said they had not read the care plans.

Some people had pressure relieving mattresses in place to relieve pressure. Most of these set themselves in accordance with people's weights, but one person did have a weight specific mattress in place. The correct setting was not written on the position change chart or in the person's care plan. The mattress was set at '6.' When we asked two members of staff what the correct setting should be, they did not know. The manufacturer guidance was found on a notice board in the office, and showed that the correct setting for the person's weight was '2-3.' A mattress that is set too firm could increase the pressure on people's skin, which in turn could increase the risk of skin breakdown.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

'My life, my preferences' documents had been completed in some of the plans we looked at, but not all. This meant there was a risk that care plans would not always reflect the ways in which people wanted to receive their care and also inform the activities and stimulation that would benefit individuals.

On the day of our inspection we did not see a dedicated activities coordinator working at the service throughout the day. We were told that one activities coordinator worked for three hours in the morning on the dementia unit. No activities were offered in the Hollies Unit. We reviewed the activities programme for the week and it lacked mental and physical stimulus. On the dementia unit the programme often only offered one activity throughout the day such as film club and soft games. No structured weekend activities were provided. The service did not enable people to carry out activities which encouraged them to maintain hobbies and interests and maintain their social skills. One member of staff told us; "There is no stimulus for people."

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the complaints file. Where issues of concern were identified they were taken forward and actioned. An example of this involved a complaint regarding the delivery of care. The deputy manager met with the relatives and provided an action plan to resolve the concerns. People we spoke with knew how to complain. One relative told us; "They seem to do a good job. I've not had to make a formal complaint. I would approach the nurse." A recent compliment had been received by the service. The staff team were praised for the care they provided to their relative. They described the staff as "understanding, supportive and efficient."

Inadequate

Is the service well-led?

Our findings

From the April 2014 inspection to the current date the service has failed to fully meet all the regulations at each inspection conducted at the location. Since April 2014 we have visited the service three times.

Since the previous inspection conducted in February 2015 the provider had failed to fully implement the actions in their plan to ensure they were no longer acting in breach of the regulations. As well as not fully implementing the stated actions in the plan we found that the number of breaches of regulations has increased. Since the previous inspection, three people had been responsible for managing the service. The high turnover of managers has resulted in a lack of consistent leadership.

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. This resulted in poor practice across the service. Medicines were not consistently administered appropriately to make sure people were safe. People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005 which provides a legal framework to protect people who are unable to make certain decisions themselves. Staff were not consistently supported through an effective training and supervision programme. Staffing levels were not maintained to the level determined by the provider's dependency tool. The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. . Care plans were of an inconsistent quality and this placed people at risk of not receiving care that were specific to their needs. Care plans did not consistently reflect the ways in which people wanted to receive their care and also inform the activities and stimulation that would benefit individuals. It was evident that systems were not being operated effectively to assess and monitor the quality and safety of the service provided. The provider's auditing systems had failed to identify the majority of the shortfalls found at this inspection and to implement their actions plans to mitigate future risks.

The provider had also failed to fully implement recommendations made in the external pharmacist audit conducted in June 2015; the quality assurance local authority report conducted in November 2015 and the safeguarding clinical nurse's report conducted in December 2015. The deputy manager who had the current responsibility of running the service was not aware of the content of these reports.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The feedback regarding the previous management of the service received from staff members and people we spoke with was mainly negative. Staff we spoke with expressed their frustration regarding the change of managers. From the comments received staff morale appeared low and they felt that previous managers did not communicate well and they were uncertain of the future of the service. One member of staff told us; "We don't know what's going on."

The recently appointed deputy manager (December 2015) appeared popular amongst staff members. Comments included; "[deputy manager's name] is supportive. He helps with staff and carers. He's hands-on

and been pushed in the deep-end. We like him and get support from him. He does listen but there's only so much he can do"; "The (deputy) manager is amazing, very empathetic and approachable"; and "The (deputy) manager will muck in if needed, I've even seen him do the vacuuming".

In March 2016 a staff engagement survey was also conducted. Mixed comments were received about the service. The majority of staff felt well supported by the deputy manager but felt improvements were still required, particularly regarding teamwork.

When speaking with the deputy manager he acknowledged that there are a number of issues that he needs to take forward. In his view this was largely due to the service not having a leader in post for a period of time. He told us that he is receiving support from the senior management team. He told us about a number of initiatives he is beginning to take forward such as introducing a regular supervision and training programme.

Until the appointment of the deputy manager regular meetings had not been held with staff members. Meetings have recently been held with staff members, team leaders and the heads of department. Issues raised included; the need for supervisions to be rolled out; the need to assess Deprivation of Liberty Safeguards (DoLS) and maintenance issues such as the need to install thermostats in every bedroom.

People were encouraged to provide feedback on their experience of the service. The service has a 'Quality of Life' programme. People have access to an iPad in the service to provide their views. According to the service "the system provides a convenient way for our residents, and those close to them, to give ongoing feedback and it immediately notifies us with the aim of us fixing it quickly." During the period 1 January 2016 – 11 March 2016 five people provided feedback. A number of positive comments were received. They included; "[person's name] has said she prefers having assistance from permanent staff only and not agency but overall happy living here"; "would have preferred to be here sooner rather than spending 12 months in hospital; "own en-suite is in good order"; and "better than previous home." Issues requested to be taken forward included extending tea-time food choices and one person thought that some staff were "rude and unsupportive." To ensure people's views continue to be sought regarding the level of service the deputy manager also told us that the service has scheduled regular resident and relatives 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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not consistently reflect the ways in which people wanted to receive their care and also inform the activities and stimulation that would benefit individuals.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not being upheld in line with the Mental Capacity Act 2005.

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 RA Regulations 2014 Staffing People were not always safe, as there were not always sufficient numbers of staff to support their needs. Staff were not consistently supported through an effective training and supervision programme.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. The provider did not consistently assess the risks to the service user and prevent them from avoidable harm

The enforcement action we took:

Warning notice

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 consistently protected people against the risk of poor or inappropriate care as accurate records were not maintained. The provider had a system to regularly assess and monitor the quality of service that people receive but this was not effective.

The enforcement action we took:

Warning notice