Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Perry Locks Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection was carried out over two days on 23 and 24 June 2015 and was unannounced.

We last inspected Perry Locks Nursing Home on 16 and 17 July 2014. At that inspection we found there were four areas where the service was not meeting regulations. These related to the monitoring of the service, staffing levels, failure to make applications to the local authority where restrictions were in place and staff training and support. The provider sent us an action plan detailing what action they had taken. During this inspection we found the provider had made applications to the local authority as required. Improvements had been made to staff training and support. We found that there were repeated concerns about staffing levels. Although improvements had been made on how the service was monitored further improvements were needed.

Perry Locks Nursing Home is registered to provide accommodation and nursing care for 128 people who have nursing or dementia care needs. There were 107 people living at the home when we visited. The home is purpose built and consists of four separate buildings. Perry Well House is for people with dementia. Brooklyn House, Calthorpe House and Lawrence House provide nursing care for older people. The service had a number

Summary of findings

of intermediate beds across the four houses. Intermediate beds means specialist care to people who have been discharged from hospital but need extra support before they return home.

A registered manager is required to manage this service. At the time of our inspection there were interim management arrangements in place. A manager had been appointed and was due to commence employment on 20 July 2015. 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.

There was not always enough staff on duty to ensure that people were adequately supervised and arrangements in place to determine safe staffing levels had not been effective. People were not always cared for in a timely manner and in a way that met their needs. This was a breach of the regulations.

There were systems in place to protect people from abuse and staff were trained and understood their responsibility to protect people from harm. However, we found that some incidents had not been dealt with in a timely manner.

People were supported to receive their medicines but some people did not receive their medicines as prescribed.

Staff understood how to gain people's consent from people and how to involve them in their care. However, we had not been notified when the local authority had approved DoLS (Deprivation of Liberty safeguards) applications. Improvements had been made to how staff training was planned and delivered. However some staff responded to people in a way that demonstrated a lack of understanding of people's needs.

Most people received food and drink based on their preference's and were provided with the support they needed to eat their meal. Some people were not offered food choices in a way that respected their needs.

People were supported to receive care and treatment from a variety of healthcare professionals and received treatment if they were unwell.

People and their relatives knew how to raise concerns if they needed to. The arrangements for managing concerns had not always been robust and timely.

Systems were in place to monitor the quality of the service but they had not always been effective and timely action had not always been taken to bring about the improvements needed. This was a breach of the regulations.

We found three breaches of the regulations. You can see what action we asked 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?
The service was not safe

People did not receive a safe service because there were not always enough staff on duty to ensure people were cared for in a safe manner.

Risks to people were not always assessed and managed.

Procedures had not always been followed to ensure people were protected from the risk of abuse.

Requires improvement

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

Staff were aware of how to gain consent to the care they provided.

Staff had received some training, further training would ensure that people's needs were met more effectively.

People were supported to receive medical attention.

Requires improvement

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

People were supported by staff that were kind and caring.

Some staff did not respond to people in a way that respected their privacy and dignity.

Requires improvement

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

People were supported to maintain contact with people that were important to them.

People knew how to raise concerns. Systems in place to monitor concerns and complaints were not always robust.

Requires improvement

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

People and staff had some opportunities to raise their concerns. However, they did not always feel that concerns were responded to.

Systems were in place to monitor the service, but these had not ensured that all the required improvements had been made.

Requires improvement

Perry Locks 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.

This inspection took place on 23 and 24 June 2015 and the inspection was unannounced on the first day but the manager knew we were returning on the second day. The inspection team consisted of six inspectors, a specialist advisor with experience of nursing and dementia care 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. On the second day the inspection was carried out by one inspector.

In planning our inspection, we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/ incidents and safeguarding alerts which they are required to send us by law. We had received some concerns about staffing levels before our inspection and we used this information to inform our planning. We asked the provider to complete a Provider Information Return (PIR) so they could provide information about the service to us including what they did well. We contacted the local authorities that purchase the care on behalf of people, to see what information they held about the service and we used this information to inform our inspection.

During our inspection we spoke with over 20 people that lived at the home, 12 relatives, 17 staff members, three healthcare professionals, the interim manager and the providers representative. We observed care in all four houses.

We looked at the care records of 11 people to check if they had received care according to their planned needs. We looked at personnel records of four staff to ensure the recruitment process was robust and we looked at other records associated with the management of the home.

Requires improvement

Is the service safe?

Our findings

At the time of our last inspection in July 2014 we found that the arrangements in place to ensure staffing levels were provided to protect people from risk were not adequate. The provider told us in their action plan that they had made improvements to how staffing levels were determined. Prior to our inspection we received information of concern regarding staffing levels at the home.

At this inspection all of the people we spoke with in all four houses told us that although they were happy with the staff that cared for them people told us that staff were not always available to help them when they needed help. One person told us, "Yes I feel safe here, it's the support from staff and the security of the building that makes me feel safe. However, there is not enough staff on duty". Another person told us, "I use to feel safe here the staff are very caring but over recent times the number of staff has reduced. I am concerned that even though the staff are good they sometimes rush my care and they don't have the time to chat with me because they are rushed off their feet".

Two people on Calthorpe House told us that they had been waiting two hours to go to the toilet. We made a staff member aware of the people's requests. We noted that although staff had been made aware the two people had to wait for a further 35 minutes before staff attended to them. On Perry Well House we saw occasions when staff had difficulty responding to people's requests for care in a timely way. We saw people wait to receive support with personal care. We saw a person being cared for in bed waited 50 minutes to receive support with their personal care and they became upset and agitated. On Lawrence House we saw that people were still been supported to get up, up until lunchtime. Staff were busy attending to people and staff told us that this was not people's choice to be getting up at this time. On Perry Well House we saw that staff were not always available to respond to request for help and we saw incidents of people becoming distressed and calling out for staff help. We saw that a number of people were being cared for in bed on Perry Well House and staff had difficulty providing care to people in their rooms and supporting people in the main lounge area.

Most relatives that we spoke with told us that they were concerned about staffing levels. They told us that this meant their family member did not always receive the care they needed in a timely way. They told us that staff were very busy. We received many comments including, "I feel the management know the care is falling short". Another relative said, "There is a chronic shortage of staff". Another relative told us that their family member lived at the home for many years and they had become increasingly concerned about the availability of staff to care for their family member. They told us that they felt people's increased dependency levels had not been considered when deciding what staffing levels were in place.

Staff that we spoke with told us that there was not always enough staff to care for people in the way that they wanted to. They said sometimes it was due to staff sickness and cover had not been provided. They told us that there were also occasions when there was not enough staff scheduled to be on duty to meet people's needs. A staff member told us, "Staffing levels are an issue, sometimes people do not go to the toilet when they want to. Some people are screaming to get up, so I have to prioritise to get these people up first". Another staff member told us, "We have lots of agency nurses with no consistency and things do not get done". And, "There is not enough staff on duty. Sometimes there is no one in the lounge, because we are giving personal care. People are not getting up until after Noon, because there is not enough staff". Many staff told us that they felt staffing levels were still based on the number of people being cared for and the increase in people's dependency levels were not always being considered by management.

Staff told us that there had been a high use of agency nursing staff. Staff told us that this had made their job more difficult. One staff member told us, "I am concerned about people's safety when the agency nurses are working. They do not know people's needs". Another staff member told us, "We do need the agency staff to help us out but it really puts more pressure on us and I don't think management always understand this". Records looked at for May and June 2015 showed that between 240 and 400 hours each week were covered by agency staff.

We spoke with the provider about how safe staffing levels were determined and also how they managed and responded to unplanned staff shortages for example, staff sickness and absences. The provider told us that staffing levels were based on people's dependency levels. They told us the minimum staffing levels for each house. We had been told by people and their relatives about specific times

Is the service safe?

and dates when staffing levels had fallen below the minimum staffing levels. For example the night prior to our inspection staff told us that there were only two care staff and a nurse working and there should of been three care staff (Perry Well House). The provider told us that house managers had not always made them aware of all of the occasions when staffing levels had fallen below the minimum level to keep people safe. The arrangements in place for ensuring sufficient staffing arrangements were not effective and did not ensure people's wellbeing and safety. These findings evidenced a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that they had experienced a very difficult period with multiple staff changes. They had recruited to a number of nursing and care staff posts and further recruitment would take place. They told us that some staff had left without notice and there had been high periods of staff sickness. Prior to our inspection they had made a decision not to admit any more people on Cathorpe House until the staff situation on there had stabilised. On the second day of our inspection the provider told us that they would be increasing staffing numbers on Calthorpe with immediate effect.

We observed senior staff on Lawrence House giving out medication. We saw that staff ensured people had taken their medicines before they moved away. One person told us, "I get all my medicines and I don't need any pain relief". Another person told us, "If I need extra medicines I can wait up to an hour, but this does not seem long to me as I know a lot of people have to wait longer". A relative told us that there had been an error with their family member's medication. They told us that the staff had notified them about it and the staff had contacted the GP for advice. They were satisfied with how it had been dealt with.

We looked at how medicines were managed on Calthorpe House and Perry Well House. We found on Perry Well House that medicines were being managed well for the protection of the people using this part of the service. On Calthorpe House we looked in detail at 10 medicine administration records and found that we were unable to fully establish whether people's medical conditions were being treated appropriately by the use of their medicines. For example we found when auditing medicines that were not contained in the monitored dosage system there were discrepancies between the quantity found and the quantity calculated from the medicine administration records. Indicating that records were not accurate and from stocks balance deduced that people had received more than/ less than was recorded. Some people would not be able to confirm if they had received their medicines or not.

We looked at the records for two people who were having the analgesic skin patches applied to their bodies. We found that the provider was not making a record of where the patches were being applied for one of these people. We found the application of the patches for the person where a record was being made was not being applied in accordance with the manufacturer's instructions. We therefore found the provider was not able to demonstrate that the skin patches were being applied safely and this could lead to poor pain control for the people prescribed these patches. Some people were not able to easily let staff know that they were in pain.

We looked at how Controlled Drugs were managed. We found that the Controlled Drugs were stored securely and regularly audited to ensure that they could be accounted for. We found that systems were not in place to ensure the safe administration of a liquid analgesic medicine for one of the people using the service. We found that the service had recorded the date of when they had opened the liquid analgesic medicine. We found that the manufacturers of this medicine stated that once the bottle had been opened the contents remaining after 90 days should be discarded. We found that the liquid medicines had expired on the 2 February 2015 and a dose was administered on the 21 June 2015. The medicines was also still available for administration on the 23 June 2015, which posed further risk of the person concerned receiving more of this out of date medicine and the medicine not being used in accordance with instructions which would impact on the efficacy of the medication and people may not receive their medicines in correct prescribed dosage.

We found that where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured that the necessary safeguards were in place to prove that these medicines were administered safely. We found that the provider had written protocols to inform staff on how to prepare and administer the medicines but they had not taken advice from a pharmacist on whether the written procedures promoted safe administration. We were

Requires improvement

Is the service safe?

particularly concerned that the staff was dissolving a modified release tablet for one person prior to administration. This was against manufactures guidance and would reduce the efficacy of the medicine.

One person told us, "Yes I do feel safe, the staff are very good". Most relatives told us that although they were concerned about staffing levels, they still felt that their family member was safe living at the home. Staff told us that they had received training in how to protect people from abuse. Staff were able to tell us what they would do if they had any concerns about people's wellbeing and they told us that their concerns would be passed onto their unit manager or the home manager. We found the home had safeguarding policies and procedures and staff also attended safeguarding training. However, just prior to our inspection we found that two concerns of poor and inappropriate care practices had not been responded and reported promptly in line with safeguarding procedures and this did not ensure that the provider's procedures were consistently followed.

During our inspection we saw equipment such as pressure relieving mattresses and cushions were in use to manage people who were at risk of developing skin damage. We found that risks to people had not always been consistently managed. A nurse told us that if a person had two falls, their risk assessments would be updated and a referral would be made to a healthcare professional to assess the risks to the person's safety so that preventive measures could be put in place. For example this sometimes meant that the use of specialist equipment such as a sensory mat may be introduced. These can help alert staff to the person getting out of bed, so staff could be on hand quickly to assist. However, we found that risk assessments for some people who had fallen had not been implemented to ensure staff knew what action to take to prevent further occurrence. We saw that a person who had recently had a few falls and had needed medical treatment. Action had not been taken to minimise the risks, and a referral to outside professionals had not been made.

All staff spoken with said that all the required recruitment checks required by law were undertaken before they started working and that they received an induction into their role. Records looked at confirmed this. The provider told us that they had recently implemented an induction for agency staff to ensure staff had the information they needed to carry out their role safely.

Requires improvement

Is the service effective?

Our findings

At the time of our last inspection in July 2014 we found that staff had not always received the training and support they needed to be effective in their role and this was a breach in the regulations. The provider sent us an action plan telling us what action they had taken to ensure staff received the training and support they needed. At this inspection we found that some progress had been made. Staff told us that they had received training in specific areas to keep their knowledge and skills updated. A staff member told us, "We now do our training updates in two whole days rather than a few hours here and there. I think this way is much better". A person told us, "I feel the staff have the correct training to care for me and most of the staff seem to genuinely care for me". Records looked at showed that over 90 % of staff had completed the providers core training.

Some staff told us that they had received a supervision session recently with their house manager. They told us that supervision session had not been frequent but was now improving. One staff member said, "I had a supervision about two months ago it was helpful". Another staff member told us, "It's good when I have a supervision session it gives your brain a bit of a think". Staff told us that they could speak to the house managers about any issues that they needed to. The provider told us that they had identified that staff had not received supervision at the frequency needed and that improvements were being made so staff received the support they needed to carry out their role.

We observed some staff interactions that demonstrated a lack of understanding of the needs of people with dementia. We spoke with the provider about this during our inspection. They told us that they had identified that some additional training and supervision of staff practice would take place to ensure that people were supported in line with their needs. The provider told us that they were also looking at ways to improve the environment for people with dementia.

At our previous inspection we found that nursing staff had not received training specific to their role so they had the skills they needed to carry out their clinical duties. A nurse told us, "I have completed an end of life course. I really enjoyed it". We found that a training plan for nursing staff was now in place so that nurses received the training they required. The training plan we saw for nurses showed that training had been scheduled to take place in July 2015 on skin integrity, nurse accountability, syringe driver and nutrition and hydration.

The Mental Capacity Act (MCA) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The deprivation of liberty safeguards (DoLS) provide a legal framework around the deprivation of liberty so people's rights are protected. At the time of our last inspection we saw that restrictions were in place and the provider had not fulfilled their responsibility by making applications to the local authority for authorisation for these restrictions to keep people safe. At this inspection we found that applications had been made for authorisation to the local authority. Although we had not been notified of when the applications had been authorised.

We spoke with staff about their understanding of MCA legislation. A staff member told us, "It's difficult to understand I think I need more training". Another staff member told us, "The last manager explained it all to us and we have some information in the office that we can look at and read again if we need to". Staff were able to tell us how they obtained consent from people on a day to day basis. A staff member told us, "I always ask people what they want to wear and what they want to eat". This showed that although some staff did not feel confident with applying the MCA principles, the practice described by most staff ensured that their practices were in line with what was required by this legislation. However, staff told us that at times due to staffing limitations they were not always able to provide care in the way that they wanted to for example a staff member told us, "I am not always able to get people up at the time that they want to get up because there is not enough staff to do this.

A person told us, "The food is very good I really recommend it". Another person told us, "The food is good you get a choice everyday". We saw that drinks and snacks were available to people throughout the day.

We observed meal times in all four Houses. We saw that on Lawrence House and Calthorpe House staff knew about the specific support people needed to eat and drink and we saw that people were supported in line with their care plan. People in these two houses made mainly favourable

Requires improvement

Is the service effective?

comments about the food. We observed that staff were unhurried in their approach. On Perry Well House we saw that people were not offered a choice at lunch time. People's meals were served up by staff and plated and we saw no attempt was made to ask people if they wanted any variation to the meal served. We asked staff about how people were involved with making choices and they told us that they had asked people the day before what they wanted to eat, and this was recorded. We saw that a person who needed some staff support to eat their meal received the support from three different staff members. Staff would give some assistance and then move onto another task and then a different staff member would take over to give assistance. This did not ensure that they received consistent support and did not enhance the person's meal time experience.

Staff told us that food records were kept for people who were at risk of becoming nutritionally compromised. However, records could not be located for two people that we asked about. We saw that some people were weighed weekly or monthly in line with their individual circumstances and risks. We saw that records of weight monitoring had not been kept for a person who had been identified as being at risk of weight loss. We made the manager aware of this during our inspection.

People told us that they were supported to see a GP, and attend healthcare appointments. Staff told us that the community matron and a GP visited the home on a regular basis [three times a week] and a geriatrician visits the home every week. Most relatives told us that they were kept informed about relative's wellbeing. A relative told us, "The staff are very good and immediately get in touch if there are any problems or if [Person's name] is unwell. Feedback from three health care professionals that we spoke with raised no concerns. However, they told us that there had been a lot of staff changes. They told us that they had requested that a permanent staff member assisted them in their role and this was provided.

Requires improvement

Is the service caring?

Our findings

All the people spoken with told us that the staff were caring. One person told us, "There should be more staff on duty but the staff that are on duty are caring and treat me with respect". Another person told us, "Staff have a caring attitude, and some of them will bend over backwards to help you".

Relatives that we spoke with told us that although they thought that there was not enough staff to care for their relative. Most were complimentary when talking about the staff who cared for their relative. Comments we recorded included, "Most staff are very good" and "They really do care about [Person's name]. Some relatives told us that they had seen some occasions when people had asked for help and staff had said they were too busy.

We observed the interactions between staff and people living at the home. We saw that mainly there was a good rapport. However, we did see a few interactions that were not respectful towards people. A staff member used inappropriate language and the tone of voice used by another staff member did not ensure that a request from a person was dealt with kindly and showed a lack of understanding by the staff member. We saw some very caring interactions staff listened to people and staff took time to reassure and communicate effectively with people. People who could tell us told us that they felt listened to by staff.

People's privacy and dignity was promoted. One person told us, "All the staff treat me with respect and observe my dignity". Another person told us, "My door is very seldom closed, but staff always knock my door before entering". One person told us that when the staff are busy they will come and explain the situation to them. We saw that any personal care was provided behind closed doors. However, we observed that some people waited for long periods of time to receive the help they needed from staff to assist them with their personal care needs. A person told us, "I have to wait a long time before they can take me to the toilet which is not only uncomfortable but can be embarrassing".

Over the two days of our inspection we saw that the home was generally busy. We saw occasions where staff responded in a timely and flexible way but this varied across the different house's and also depended on the time of day. At times staff had difficulty responding to people's requests for care in a timely way. Most staff that we spoke with knew people needs. A few staff that we spoke with had only limited knowledge of people. This was because they were either newly employed, agency staff or working on a house they were not as familiar with due to staffing shortages and had not received an adequate introduction to what was happening and what the needs of people were. The provider told us that they recognised the need to provide consistent staffing across all the house's to ensure people received continuity of care.

Requires improvement

Is the service responsive?

Our findings

Most people who were able to give an opinion and relatives we spoke with told us that staff did speak with them about their care. One person told us, "Staff ask me how I want things done". Another person told us, "I can't remember ever having a meeting to discuss my care; I would tell my family if I had any concerns about my care and they would take it up with the staff". Most relatives that we spoke with told us that staff kept them informed about their family members health and care matters, although one family member said there had been a delay in informing them about their family member needing hospital treatment.

The provider told us that new assessment and care plan documentation was in the process of being implemented across the service. We saw that the new documentation asked for people's information in a more personalised way including information about people's personal history and preferences. We looked at 11 care records across all houses and we found that four people's care records had not always been maintained accurately with information relating to their needs or updated when people's needs had changed. We asked staff about people's care needs and most staff could tell us what the person's care needs were and how these were being met. For example we saw that a person was upset at meal time we asked staff about this. They told us that the person was previously able to assist themselves but now needed staff assistance. Staff told us that sometimes the person became agitated at meal times because they were frustrated about the skills they had lost. Staff told us how they supported this person and we observed this during our inspection. However, the person's care records had not been updated to reflect the change and to ensure staff had the information so the person would be supported consistently. Some staff were unfamiliar with people's needs and when we asked specific information they were vague about people's needs. A nurse in one house did not know how many people were being cared for in bed. A staff member in another house did not know the name of a person living at the home who we were asking about.

We spoke with a person and their family member who had recently moved into the home for short stay. They told us about their interests, likes and about their preferences for particular items of clothing. Their relative told us that staff had not asked them for personal information such as their likes, dislikes and their hobbies and interest. We asked two staff about this and they did not know this information, and it was not recorded in the person's care records. Another relative whose family member was also receiving short term care told us that they had not felt involved and consulted with about their family member's short term placement at the home.

Staff told us that a handover took place between staff members to keep them informed of people's changing needs. Most staff told us that they felt they were kept informed about people's needs. Although two staff members told us that they felt handovers did not always give them the information they needed. One staff member said, "It's a bit rushed at times".

We saw on Lawrence House that staff encouraged people with walking frames to walk and we saw staff using a standing hoist.

The provider told us that the individual house managers were responsible for carrying out assessments on people to establish their suitability for the home and the most relevant 'House' to suit their needs. Some house managers told us that the complexity of the needs of the people admitted to the home was at times challenging for them. For example at Perry Well House which was for people with dementia was also caring for people with end of life care and there was also a number of people who were on interim beds requiring differing levels of care. We saw that there was no directional or orientation signage in place and the layout of Perry Well House included long winding corridors. We asked the provider about this. They told us that they would be consulting with people and their relatives about the purpose and focus of each of the four houses, and the management of interim beds to improve people's quality of care.

We asked staff how they managed behaviour that may challenge. Staff told us that they would reassure the person and offer a drink of maybe something to eat. We saw some incidents where people were upset and distressed and there was a delayed response from staff to reassure people and some staff seemed unsure what to do. We also saw some very positive and caring responses from staff who knew people's needs and knew how to reassure people and did so in a kind and caring way. We saw that care records included behaviour management plans but these did not always include information about how to defuse frustration or distress for an individual.

Requires improvement

Is the service responsive?

People were supported to maintain contact with friends and family. People and relatives told us that they could visit throughout the day and we saw visitors come to the home throughout the day during our inspection. A relative told us, “I can visit at any time and I always get a cuppa”.

We looked at the daily social activities that people engaged in. We saw variations across the different house's and we also saw differences on both days of our inspection. People who were able to join in activities or enjoy their own hobbies and interest were generally satisfied with the level of activity within the home. One person told us, “I join in the bingo session which I enjoy”. Another person told us, I like watching sport in my own bedroom and I read the daily newspaper”. We saw that the person was supported to do this. Another person told us, “I go to the church service on a Monday it makes me feel brilliant”. On some house’s we saw activities taking place organised by staff with a specific role for initiating activities. We saw people involved in a quiz which people told us they had enjoyed. We also saw long periods of inactivity, for example on the first day of our inspection on Perry Well House we observed care from 09.30 in the morning and we saw that some people sat in the chairs all morning and there was little or no engagement from staff. It was a warm and sunny day when we visited and the doors leading to the garden remained locked throughout the day and some people requested to go out for a walk. On the second day of our visit on Perry Well House there was a staff member present to initiate activities and we saw people engaged in conversation and social interaction which helped people to have a greater sense of wellbeing, and the doors to the garden were open.

Some people told us that they would speak to a staff member or a family member if they were not happy about something. Most people that we spoke with were aware of the complaints procedure. Relatives told us that they would usually speak directly to staff or the house manager if they had any concerns. We saw that information about how to raise concerns were available in public areas for visitors and the people that lived there. We saw that there were systems in place for recording and investigating complaints. However, records looked at showed that it was not always clear what action had been taken to resolve concerns and showed that not all concerns were recorded and responded to in a timely manner.

Requires improvement

Is the service well-led?

Our findings

At the time of our last inspection we found four breaches of the regulations relating to staffing levels, a lack of staff training and support, failure to make DoLs applications and failure to monitor the service effectively. We received an action plan from the provider setting out what they would do. At this inspection we found that some improvements had been made to the arrangements for staff training and support. Improvement had been made with the applying of DoLS and applications had been made to the local authority. However, we found that some people's applications for DoLS had been approved by the local authority. However, we had not been notified of these decisions. It is a legal requirement for the Care Quality Commission to be notified of these. This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a quality assurance systems in place based on auditing of the service at regular intervals. The results of the audits were fed through to higher managers in the company. Areas that needed improvement were picked up and an action plan was devised to help ensure continual improvement. We saw reports of audits completed by the individual house managers, the site manager and the provider's representative. We saw that in May 2015 the provider had implemented a comprehensive improvement plan to improve the standards of care and to re-establish confidence in the service. A new care plan system was in the process of being implemented, a recruitment drive had taken place and a staff training plan was in place. The deputy manager had taken a lead on medicine management to improve practice across the service. The provider had a system in place to monitor trends in respect of accident, incidents and safeguarding incidents. However, our findings were that information in relation to these were not always communicated effectively and recorded. Therefore the provider could not be confident that their analysis of these would be an accurate reflection of the service. Improvements were needed to some people's care records to ensure that they were accurate, complete and contemporaneous record. We found failings again in the arrangements in place to ensure effective staffing of the home. The systems in place to ensure that staffing levels and staff absences were managed had not been effective. This is a breach of regulation 17 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014.

At the time of our last inspection in July 2014 the provider had shared with us their concerns about the management arrangements for the home. They had replaced the previous management team and interim management arrangements were in place when we visited. Shortly after our visit a permanent manager was appointed and registered with CQC. In March 2015 the registered manager resigned from their position. At this inspection once again the provider had interim management arrangements in place. The provider's representative had based herself at the service to support the temporary arrangements. The manager's position had been appointed to and the new manager was due to start at the service on 20 July 2015. The provider has kept us informed of the management changes and told us of the action they were taking to resolve the situation therefore ensuring that they fulfilled their duties to have someone in day to day control of the service.

Most of the people and relatives that we spoke told us that they knew who the individual house manager and overall site manager was. People and their relatives told us that if they were not happy about something they would usually speak to the staff in the house they lived in, or they would speak with the house manager. Some relatives told us that concerns had been raised about staffing levels with the site manager, and they did not feel that the provider was taking action to improve things.

All staff that we spoke with understood their responsibility to share any concerns about the care of people living at the home. All staff that we spoke with were aware of the provider's whistleblowing policy. Staff told us that they would raise any concerns if they needed to and they had raised their concerns about staffing levels. Staff told us that the home had continued to endure further management changes and this had been unsettling for the home and had affected staff morale. Most staff that we spoke with felt that the provider was not listening to the concerns that they were raising and had not taken enough action to improve the staffing levels in the home.

We saw that there were some formal processes in place to get feedback from people's relatives. We saw the results of the survey that was published in May 2015. Areas for

Requires improvement

Is the service well-led?

improvement identified were 'promptness of staff attending to my relatives needs' and 'listening and responding to requests'. However the provider needed to consider if this was an effective method or not as only 12 relatives for a 128 bedded home had completed the survey.

We saw records of minutes of meetings that had been held with people and relatives to gain their views and we saw relatives concerns about staffing arrangements were recorded in these. The manager told us that meetings had been infrequent and they had arranged more frequent meetings to encourage attendance and feedback.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified CQC of applications agreed by the Local Authority to restrict the liberty of people living in the home.18 (1) (4B)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems in place were not operated effectively to ensure compliance with the regulations. 17 (1) and 17 (2) (a) and (b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet people's needs. 18 (1)

The enforcement action we took:
Warning Notice