Rockley Dene Homes Limited

Candle Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Candle Court is a nursing home providing accommodation and care for up to 93 people, some of whom have dementia, physical disabilities and mental health needs. At the time of our inspection there were 74 people living at the service.

The service did not have a registered manager in post. This 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. A new manager had been appointed in June 2016 and would be submitting an application to become the registered manager.

At our comprehensive inspection in July 2015 we found that the provider was in breach of standards relating to medicine management and the numbers of hoists and slings available were insufficient to meet people's individual needs.

At our last inspection in February 2016 we found the provider had made improvements to the way medicines were managed and the number of hoists available and in working order had improved. However, we noted new concerns. Staff were crushing tablets before administering them to some people, before obtaining authorisation from the doctor or pharmacist. Although there was a process for two nurses to check that the dose of warfarin administered was correct, these checks were not thorough enough, as staff had placed the wrong blood test result with someone's medicines administration record. These issues were rectified during the inspection. Staff training had not been effective in ensuring that staff implementation of moving and handling techniques were correctly completed. We observed poor moving and handling techniques. The provider was not meeting the legal requirements for consent to care and treatment and staff training. We found that people who lacked capacity to make decisions about their care and treatment did not have their mental capacity assessed by staff before making a decision to administer covert medicines (medicine hidden in food) and there was no evidence that decisions had been made in their best interest.

We told the provider to take action to make improvements. We received an action plan from the provider stating that these issues would be addressed.
At this inspection on 22 and 27 July 2016, we found the provider had not made enough improvements.

The protocols for giving people some medicines were not person centred and did not always reflect people's individual needs. Risk assessments were not detailed and did not provide information on how to mitigate risks. We observed that staff were rushed and unable to provide the care people needed due to insufficient staffing levels.
Care records had not been reviewed to ensure they were up to date and accurate and audits conducted were not effective in ensuring that problems found on the day of our visit had been addressed. Hoist equipment was not sufficient to meet people's needs and medicines were not always given safely.

There was a staff recruitment procedure in place and the necessary checks carried out prior to staff working for the service.

People's individual needs were not always met by the service and people reported that staff did not always respond to people's needs in a timely manner. Call bells were not always responded to and some people said they were told not to use their call bells.

Although we observed people being treated with dignity and respect, people's dignity was not always respected as they were having to wait too long to be assisted with personal care.

People were given a choice of meals from the set menu and gave mixed feedback about the quality of the food.

We observed that staff were caring and kind when interacting with people and providing people with personal care.

The management arrangements before the current manager started in June 2016 were not effective as the provider had not identified risks to people's safety and wellbeing and had not made necessary improvements to the service. The audits carried out did not identify areas for improvement with medicines, staffing, recordkeeping and responding to unexplained injuries. The provider also failed to act on the recommendations of a pharmacist to make necessary improvements in managing medicines for people.

We found breaches of regulations relating to reporting of safeguarding incidents and responding to unexplained injuries, assessing risks to people's safety, medicines, moving and handling equipment, staffing levels, care records and quality assurance.

We took enforcement action against the registered provider. We imposed a condition on the provider to prevent them from admitting any new people to Candle Court without the prior written agreement from the Care Quality Commission.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Staffing levels were insufficient to meet people's needs. Medicines were not properly managed. Risk assessments lacked detail on how to manage some areas of risk. People needing one to one staff support did not have care plans explaining their needs.

Is the service effective?

Requires Improvement

The service was not always effective. Staff understood the importance of asking people for their consent before providing care. Staff gave mixed feedback about the support they received from managers. The service worked with other healthcare professionals to ensure people's needs were met. People were given a choice of food from the menu

Is the service caring?

Good

The service was caring. Staff were caring and understood people's needs. People were treated with dignity and respect

Is the service responsive?

Requires Improvement

The service was not always responsive. There were times when staff did not respond to callbells promptly and people had to wait to be supported with personal care. People participated in activities, however, people who were unable to participate in the planned activities did not always have their needs met. People and relatives knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not always well led. There was no registered manager. People and relatives felt the service had made improvements but we found. systems were not effective in identifying and acting on the issues found on the day of our visit. Care records were not accurate and up to date. The provider had not learned from and acted on concerns found at previous inspections to mitigate risks to people's health and safety.

Candle Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 22 and 27 July 2016 and was unannounced.

The inspection team consisted of one inspector, one specialist professional advisor in occupational therapy, a pharmacist inspector and two experts- 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.

Prior to the inspection we reviewed information we held about the service. This included information sent to us by the provider about the staff and the people who used the service, notifications received from the service including safeguarding notifications.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.
We talked to 12 people using the service, seven relatives, a GP visiting the home and 15 staff including the new manager, staff nurses, unit managers, care workers, activities coordinators and housekeeping staff. We also spoke to three local authorities funding care at the service. We reviewed care records and risk assessments for 13 people using the service. We reviewed training records and staff personnel information for staff and reviewed medicine administration (MAR) records for 40 people. We also looked at complaints, incidents and safeguarding records. We inspected the building including the equipment used to help people with their mobility.

Inadequate

Is the service safe?

Our findings

People gave us mixed feedback about whether they felt safe at the service. One person told us, "It's quite a good service. The care makes me feel safe."

We noted that there were five incidents involving unexplained bruising since February 2015 that had not been investigated, none had been reported to CQC, and only one had been reported to the safeguarding authority. Although staff were able to tell us the signs and types of abuse they would look for and the action to take, people were not always protected from possible abuse, because the provider had not taken appropriate action to report possible safeguarding incidents. Some records of people being found with unexplained injuries did not show evidence that any action was taken to investigate the cause of the injury or to seek medical attention.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

During our inspection we notified the manager of a possible safeguarding issue, this was acted on promptly by the new manager who immediately submitted a safeguarding alert.

Medicines were not always managed properly. Some people were prescribed medicines to be taken 'when required'. In two cases we saw that a clear care plan had been written detailing when the medicine should be used and what signs staff should look out for when deciding to administer it. However we saw other instances where there was no clear care plan and the information available was generic and not person centred. In two cases we saw errors in the information which could be misleading. This meant that people may not get their medicines when they needed them in a consistent way as many of these people were unable to articulate their needs.

We were told that a number of people had their medicines covertly. This means that their medicines are given to them disguised in food or drink as it had been agreed that it is in their best interests to do so. We saw that mental capacity assessments and best interests decisions were noted for these people, however there was insufficient information to support nurses to give these medicines safely.

The service had not obtained advice from the pharmacist as to how to give the medicines and whether they were suitable to be crushed or dissolved. We saw one medicine prescribed for someone covertly that should not be taken with food, or crushed. The nurse on duty was aware of this but there was no information to guide staff as to how to enable this person to take their medicines safely and there was no review noted as to whether it was appropriate to continue with this medicine.

One person was prescribed two medicines that had labels specifically stating 'do not crush or chew' one of which also stated 'swallow whole at least 30 minutes before food'. The information staff had recorded for covert administration stated 'in desserts or tea'. The nurse on duty told us that she would administer this correctly but we had no assurance that all nurses would do so. Crushing medicines changes their properties

and can lead to an incorrect dose being administered.

During the inspection we were shown new forms that were to be sent to the pharmacist to obtain further information on how these medicines should be administered.

Medicines were stored securely and appropriately, including controlled drugs and those that required refrigeration. We noted that a problem had been identified with one of the fridges and a new one ordered promptly. Medicines were available for people and nurses could describe how they could obtain medicines in an emergency. Medicines were disposed of appropriately and records kept.

Medication administration records (MAR) were clear and included photographs for identification, where permission had been given, and allergy status. Refusals were noted and discussed with the GP. We did not see any gaps or omissions on the MAR, however the daily audits that nurses carried out showed that they frequently found gaps when checking the MAR. These individual errors were corrected but we did not see any specific actions to address the trend. Some people were prescribed medicines that needed regular blood tests to determine the dose. We saw that these had been done correctly and the dose adjusted according to the clinic's instructions. Creams and lotions were applied by care staff when supporting people with personal care. These were recorded on separate forms with body maps describing where to use the creams. Care staff described to us how they did this and the support and training they received from the nurses.

Nurses took time to encourage people to take their medicines and were aware of people's specific needs. .

Risk assessments reviewed covered risks of falls, pressure sores and moving and handling. We saw that three for people at moderate or high risk of falls, had been assessed using a falls risk assessment scoring tool and a care plan for falls prevention had been completed. We reviewed risk assessments for four people in relation to moving and handling. All required two staff for transfers. We noted that the risk assessments were brief and generic, for example these stated 'requires assistance from 2 staff for manual handling' or 'assistance of 2 for transfers.' Most risk assessments had been reviewed. However risk assessments did not always reflect the risks posed to people using the service including one person who had behaviours that challenged the service and also had complex care needs. We observed that when this person was being hoisted they required three staff members to hoist them from their chair to bed. The risk assessment however had stated that they required assistance of two staff using a full hoist. There was no mention of how the person's behaviour could impact on manual handling and the risks. The risk assessment and care plan therefore did not accurately reflect the person's level of risk.

We reviewed hoisting equipment used to transfer people. We saw that there were two standing hoists and one full body hoist on the ground floor and two standing hoists and three full body hoists in situ on the first floor. Staff informed us that there were usually four full body hoists on the ground floor. All hoists had an up to date service sticker log indicating that these had been serviced in March 2016 and were due to be inspected again in September 2016. We checked five hoists on the ground floor and noted that one was not working and two did not have the battery in situ therefore could not be used immediately. We also noted that the room where these were stored had only one socket, this would only allow staff to charge the battery for one hoist at any given time. This put people at risk of not having their needs met and would impact on how quickly staff were able to provide personal care to people who needed a hoist to go to the toilet.

The new manager provided us with a list of people who required the assistance of two staff for hoisting, which showed 20 people required hoist transfers and two staff for assistance.

Staff confirmed that there was no written inventory of the manual handling equipment used at the service or a log book detailing which equipment is being used when and where at any given time. This made it difficult for staff to keep a track of the location of equipment and they did not have immediate access to equipment to meet people's needs.

Staff told us that there were sometimes issues with the reliability of some of the hoists. A staff member reported on several occasions, the hoist had stopped working whilst staff were transferring a person, and therefore they had to use the emergency button to complete the transfer. This put the person at risk of falling. Staff reported that they were having to wait for availability of hoists and that "morning times were the worse." They also told us that one particular standing hoist was sometimes "unreliable" and "slow." Staff felt that the service needed more hoists to meet people's needs.

We observed staff carrying out four transfers using hoists. All required assistance of two staff using either a standing hoist or full body hoist. We saw that staff had safely transferred three of the four people without any concerns. However, whilst using a standing hoist to transfer one person from their wheelchair to the chair, the hoist stopped working during the transfer. The staff member therefore used the emergency button to lower the person safely. They however, did not put the wheelchair brakes on whilst the resident was being hoisted up from the wheelchair. This put the person at risk of falling and sustaining an injury.

We saw that people had individual slings for use with a hoist stored in their own rooms and most were labelled with their name. We noted that some people had a notice on the wall of their room, which showed a picture of the style of hoist and size of sling to be used. We saw that one person had a sling belonging to another person in their room.

Care plans covered various areas, including manual handling needs such as type of hoist required and in some cases size of sling. We noted that in one person's care plan this stated that "bedroom lights need to be in good working condition ." and "The nurse in charge should be informed if there were any electrical faults." We observed when the person was being hoisted, staff found that two of the lights in the persons room were not working, only the side light was working. The maintenance checklist showed that all the lights were working on 27 June 2016. Insufficient lighting could put a person at risk if staff were not able to see properly when supporting them. Therefore care was not provided in accordance with the person's plan of care. For another person we saw that their care plans related to mobility and communication for example had not been reviewed monthly as indicated. We found gaps of seven and 11 months where these had not been reviewed. In their communication care plan this had stated that staff should, 'check every 30 minutes observe non-verbal to monitor distress,' This person was not receiving care in line with their care plan as they told us that they had waited an hour before being assisted.

The service had started to develop support plans for people receiving one to one care. We were shown two completed one to one support plans by the project manager who told us that they were in the process of creating support plans for everyone receiving one to one constant support. This provided details of how each person was to be supported and the hours of support required. Records showed that there were 10 people currently receiving one to one constant supervision. Although staff were able to tell us about people's needs in respect of their one to one care, care records were not in place to provide guidance for staff on how and what support they were required to provide. Some staff told us that this would have been helpful when they first started. Some people received one to one care as their behaviour was at times a risk to others and a lack of record about this and how to support the person in order to protect others put other people's safety at risk. This lack of risk management meant that service users were at risk of harm as some staff may not know the specific risk to their health, safety and wellbeing that required one to one staffing and therefore may not be able to mitigate the risks and keep people safe.

There was a system in place for recording and dealing with incidents. We asked the provider to send us details of incidents and accidents since January 2016. We saw that this included, for example, the type of incident, immediate action taken and any preventative actions taken. This also looked at date/times when incidents had occurred and whether the person was taken to hospital. We noted that there were some gaps in information documented in the report sent to us by the provider. The outcome was not always documented and some incidents were not dated.

We concluded that the above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The new manager and deputy manager told us that there was a total of 26 staff on duty at the home, 13 allocated on each floor. Staff reported that there were not enough staff on duty to meet people's needs. Some staff told us they felt rushed and overworked. Staff responsible for administering medicines told us that they did not have sufficient staff to allow them enough time to carry out the monthly medicines order and often had to stay late to do this in their own time. One staff member said, "We are struggling here for staff" and told us that most of the time they were short staffed and the service does not call for agency staff to replace permanent staff when they are unable to work. We were informed by staff that there were issues with staff not attending work or contacting the service when they were unable to attend. Additional staff were not allocated to replace absent staff so staff from one unit would work in the other unit, leaving their own unit short of staff.

We reviewed the staff rota for 27 July 2016 and noted that this did not accurately reflect the number of staff on duty that day. We saw that nine care staff were on duty on the ground floor, however the rota indicated that this was 13 staff. The deputy manager told us that one person had refused to attend and had not made any contact

Staff records showed that the staff ratio was one staff to six people, as two care staff worked in pairs and looked after 12 people on each shift. Staff told us that they did not prioritise who to provide care to first, they would try to start with people who required less support. Staff told us that each person took up to 30 minutes, sometimes more to have their personal care in the morning. We noted that this meant some people had to wait for their personal care and so had to stay in bed longer than they might wish to. We reviewed records and looked at people's level of needs. Records showed that three people on the ground floor required one to one constant support, this ranged from 12 hours to 24 hours, seven days a week. 10 people required hoisting on the ground floor 5 of whom required two staff members for transfers. This showed people had a high level of support needs which the staffing levels may not be able to meet.

We spoke with 15 staff, 12 told us that staffing levels were not adequate to meet service user's needs. Staff told us they felt overworked and that this had been going on for approximately three months. Some staff were moved from the unit they were working in and deployed in another unit to cover staff shortages. Staff told us that at weekends, there was often not enough staff on duty and people receiving one to one care were often left in their rooms alone because there were not enough staff on duty to provide them with the care they needed. Staff said they did not have enough time to do everything which meant that people often had to wait longer before being assisted. On the first day of our visit we saw that people on the ground floor did not get their morning tea as staff were not available to make it for them. On the second day of our inspection we noted that one person had waited 45 minutes as staff were not available to assist them. People were not receiving the care and treatment they needed because there were insufficient staff to meet their needs.

We asked the deputy manager about staffing levels and told them about our concerns that this impacted on

people who used the service. The deputy manager told us that they had conducted a needs assessment on five people with high needs and had concluded that each person required 45 minutes for personal care. The project manager told us that the service had commenced interviews for two team leaders for each floor.

The above is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We saw that the service had a recruitment policy and procedure. We asked the manager to provide us with information about the staff employed by the service, this included Disclosure and Barring Service (DBS) and reference checks . We spoke with the director of Human Resources (HR) who told us that they conducted yearly audits on staff recruitment files, the last had taken place in July 2015. This resulted in an action plan. She told us that the service would carry out DBS reviews every five years as part of best practice. Records seen showed that 25 of the 115 staff members employed by the service between 2003 and 2010 were due to have their DBS renewed. The director of HR told us that this would be actioned immediately.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) 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. Staff understood the importance of asking people for their permission before providing care. We saw that records contained information of best interest meetings concerning the use of covert medicines signed by the pharmacist and GP.
People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 saw that care records contained DoLS which had been authorised by the relevant local authority. Staff records confirmed that they had received training in DoLS and the MCA. Staff had some understanding of DoLS.

Supervision records reviewed showed that some staff had last received supervision in July 2016, prior to this supervision was last carried out in December 2015. These were generic supervision sessions which focused on specific topics discussed with all staff, for example, high risk of choking following an incident and gaps in MAR charts. We saw that the service had a supervision matrix for 2015. However, we noted that supervision did not afford staff the opportunity to reflect on their individual practice. Most staff said they felt supported by the manager, although some staff did not feel their managers listened to them.
We recommend that the provider follows good practice in providing regular supervision for all staff which supports them to work effectively..

The service staff training matrix showed that staff had completed training in areas such as, dementia awareness, dignity and privacy, manual handling, infection control and health and safety. This was confirmed by staff who told us that they had received training in these areas in the last six months.

We observed mealtimes at the service and saw that a number of people required assistance by staff to eat. In one dining room we saw that people were offered a choice between orange juice and blackcurrant, there was music playing in the background. A staff member took a tray around offering fish and chips or fried fish, mashed potato and peas. She asked people which one they wanted. The temperature was checked on all the food and recorded. We saw that staff assisted people in a caring and encouraging way. One staff member took their time and helped one person to finish their meal.

We saw that some people were on special diets such as pureed food. This was not always presented well. We saw two examples where the food had been mixed together, we had to ask staff what the food contained as it was not recognisable. For another person we observed that they needed support with eating and drinking. They were having difficulties using their right hand, for gripping and holding objects such as cups. We observed a staff member provide the person with a drink and a straw. The staff member kindly and gently talked to the person and helped the person to drink with the use of a straw for a few minutes, but

then left. The person was unable to continue drinking because there was no one around to assist them. This put the person at risk of dehydration as they may not have received enough fluid.
We recommend the provider seeks advice on best practice to improve the mealtime experience for people.

People had support with their health needs. Staff referred them to healthcare professionals when needed. The GP visited the home regularly to see people who were unwell. We saw that care records included information about people's professional visits, such as appointments with the opticians or physiotherapist. One healthcare professional told us that staff were, "very good," at making referrals to their service.

Good

Is the service caring?

Our findings

We observed good interactions between staff and people who used the service. Staff were caring and attentive and constantly reassured people when providing care. One person told us that the home is, "A good place…things are improving." A healthcare professional told us that staff went, "out of their way" and that care staff were, "wonderful."

We observed that staff treated people with dignity and respect. When transferring people using a hoist we saw that staff talked through what they were going to do and obtained people's consent before providing care, they then gently explained each stage. In one example we observed staff interacting with compassion when encouraging one person who refused personal care. Staff spoke to the person with respect when asking the person whether they would like a wash, the person initially said no and staff then asked if they could return later to see how the person felt, they agreed and a few minutes later the person accepted personal care.

Staff had a good understanding of people's needs, preferences, likes and dislikes. For example, staff told us of one person who used gestures to indicate what they wanted. They said "My duty is to read the care plan to see what is needed and get a history about the person and how to communicate effectively." Staff told us that it was important to ask people what they wanted, "I always ask if they want a cup of tea."
A handover meeting was used to inform staff of any changes to people's needs. .

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. Some people told us that staff did not always respond to their call bell. When they did they would turn this off. One person told us that that staff were very caring but they did not always have the time to respond to their needs. One person told us that staff, "Sometimes come and sometimes they don't, but they can hear you." They also said that staff can sometimes be, "Rough and sometimes good," when transferring them." Another person told us that they used their call bell a few times but staff "Tell you off. It's like being in prison." We brought this to the provider's attention at the end of the inspection. We saw that some people had their call bells in reach, however one person with mobility needs did not have their call bell in reach. .

Relatives felt on the whole the service had been responsive to their relative's needs. They told us that staff would contact them if there had been any changes to their relative's health. One relative told us that their relative's health had improved since joining the service and that they had gained weight which was positive.

On the day of our visit we observed that staff were unable to respond to people's needs. We noted on several occasions that the call bell would ring for several minutes before being answered. One person reported that they had been waiting "ages" for staff to assist them to hoist them onto a commode. We observed, whilst this person was waiting two different members of staff on separate occasions responded to the call bell, but when they realised that the person needed two staff members to transfer them, they left to say they needed to find an extra person to assist. The person became increasingly distressed and agitated until staff did come and assist them. . We saw that some of the staff found the interaction with the person challenging and expressed this afterwards.

The service employed an activities coordinator who we saw on the day of our visit. An activities programme was displayed on the notice board. This included activities such as light exercise, film and manicures. A Sunday church service was held for people wishing to attend. We saw that people participated in activities on the day of our visit. In one lounge we saw that people were playing ball with a staff member. We saw that at one point people were sitting doing nothing for 15 minutes, until a family member took a ball and started passing it around to people. During this time there was very little interaction between staff and people using the service.

People unable to participate in group activities did not have their needs met. We saw that two people were not able to go out or use the communal lounge because they did not have a wheelchair. The deputy manager told us that they had looked into this and had discussed this with relatives. He also told us that this would there would be a cost as the service did not provide wheelchairs. We spoke with a relative who told us that they did not understand why this was not provided by the service.

The service had a complaints policy. We saw that the service had recently introduced a comments and complaints box in main reception area. A poster on how to make a complaint was displayed on the notice board in the communal entrance area. This mentioned the local safeguarding team, however contact details were not provided. We informed the new manager about this and she informed us that she would

ensure that this was updated.

Inadequate

Is the service well-led?

Our findings

The provider appointed a new manager in June 2016. The previous registered manager left in February 2016 and senior managers from head office ran the home during this period prior to the new manager starting. The new manager was supported by the project manager a few days a week and as and when they needed their support.

People who used the service and their relatives were able to give their views about the service. One person told us, "It's ok." A relative told us that the new manager seemed, "determined to improve things." They also told us that there had been a turnover in staff with the, "Good ones moving on." A healthcare professional who regularly visited the service told us, "I'm quite happy with the new manager. I had good support prior to this also."

We received mixed feedback from staff about the way the service was managed. One staff member told us, "The manager is trying to improve quality for both people who use the service and staff." However, they also told us that the service was still lacking in amenities, for example struggling with the number of hoists. Another staff member told us they felt management did not always listen to them. The feedback about the new manager was mostly positive.

We found concerns that we had brought to the provider's attention on previous inspections remained a concern and had not been used as learning to make improvements. Audits carried out by the service included health and safety checks, medicine audits and infection control audits. We saw that the supplying pharmacist visited the service to audit the medicines and documentation 6 monthly. At their last visit in April 2016 they noted concerns with 'as and when required' and covert medicines documentation. This had not been followed up until it was noted on an internal audit in July 2016. The provider's medicines audits had not addressed this concern. This is a failure to mitigate risks for people using the service and a failure to act on the recommendations of a specialist.

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

We saw that the new manager was keen to improve the quality of the service and had introduced a manager monthly Saturday surgery with manager and deputy manager displayed on notice displayed on ground floor entrance door. People could book 15 minute appointments to talk to the manager. Dates from August to December 2016 were displayed for people to book themselves an appointment.

Family notice boards contained information for relatives, about planned relatives meetings for 2016.
Following our inspection, the provider submitted an action plan outlining how they would be addressing some of the issues raised on the day of our visit. For example, system to address staffing levels on the ground floor. This included better monitoring of and cover for staff absence.
We also received information at our request from the provider confirming that they had , after the inspection, increased staffing, reviewed moving and handling care plans, produced support plans for

everybody who had one to one staffing and were seeking specialist advice to resolve the concerns we found with medicines.
The newly appointed manager had introduced champions in areas such as, care plans and care records such as fluid charts, infection control, health and safety, safeguarding and DoLS to encourage improvement.