Four Seasons (No 10) Limited

Summerdale Court Care Home

Inspection report

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Date of inspection visit: 12, 13, 15 and 22 October 2015
Date of publication: 10/02/2016

Ratings

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

Overall summary

The inspection took place on 12,13,15 and 22 October 2015 and was unannounced. The home was last inspected in October 2013 and at that time was compliant with all the outcomes inspected.

Summerdale Court Care Home is a large, purpose built care home with nursing with capacity to support 110 residents. 88 people were living there at the time of our inspection. It is divided into four units, two residential units and two with nursing care. At the time of our inspection there was a registered manager in post. 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.

Summary of findings

People and their relatives told us the staff were hardworking and people's dignity and privacy was respected. There were enough staff on duty during our inspection.

People told us they did not always feel safe and records showed that incidents were not always reported on to the relevant authorities. Risk assessments were not robust and did not provide sufficient detail to mitigate risks identified. There were inconsistencies in how risks were managed and this put people at risk of harm. Medicines were not always administered as prescribed and the administration of controlled drugs was not in line with legal requirements. Health and safety checks of equipment and routine maintenance tasks were not being completed.

Care plans did not contain enough information to provide good care. The review and audit mechanisms were not effective and plans were not updated to reflect changes in people's needs.

People had sufficient food and drink to keep them healthy. However, some people had to wait to be supported to eat their meals which meant they were no longer warm by the time they were eaten. People's healthcare needs were being met. The GP visited the service twice a week. Visits from other healthcare professionals also took place.

Consent was not sought in line with legislation and records were not clear about whether or not people had consented to their care. Where people required Deprivation of Liberty Safeguard authorisations the appropriate authorisations had been sought. However, the service had not notified CQC of this as is required.

Staff training was not sufficient to ensure that staff had the correct skills to carry out their roles.

People were not always involved in making decisions about their care and the home did not always respected where decisions had been made regarding end of life care. We have made a recommendation about end of life care.

Staff treated people with dignity and respect, although they did not always show understanding of sexuality issues in care homes. We have made recommendation about equality and diversity.

Staff recruitment procedures were safe and most employment files contained the relevant checks to help ensure only appropriate people were employed to work in the home. We have made a recommendation about employment references.

Group activities were available to people living in the home. People who did not leave their rooms did not access activities.

There was a complaints procedure available to people in the home and records showed complaints made had been appropriately responded to.

Quality assurance and audit mechanisms were ineffective and did not ensure the service was delivering good care.

We found seven breaches of regulations. We are taking enforcement action against the registered provider. We will publish an update to this report when this is completed.

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.

Summary of findings

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.

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 were not protected from avoidable harm and abuse because incident reporting and investigation was not robust.

Risk assessments were not robust and did not provide the information needed to keep people safe.

Medicines were not always administered as prescribed.

Staff recruitment was not always robust in terms of checking staff references.

Inadequate

Is the service effective?
The service was not effective.

Staff did not receive the training they needed to give them the knowledge and skills they need to carry out their roles and responsibilities.

Consent to care and treatment was not always sought in line with legislation and guidance.

People were supported to have sufficient to eat and drink and their healthcare needs were met.

Inadequate

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

Staff built up positive caring relationship with people using the service.

People were not always supported to express their views or be actively involved in making decisions about their care.

People were not supported to express their wishes about how they wanted to be supported at the end of the lives.

Requires improvement

Is the service responsive?
The service was not responsive.

People did not receive personalised care that was responsive to their needs as care plans lacked detail and were not updated to reflect changing needs or preferences.

Feedback from people was not used to drive improvement and lessons were not learnt from incidents.

Inadequate

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

There was an unhappy culture among staff.

Inadequate

Summary of findings

Quality assurance and audit systems were not effective.	

Summerdale 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. We are taking enforcement action against the registered provider.

The inspection was unannounced. The inspection team consisted of two inspectors, a specialist advisor with expertise in nursing care and two experts by experience. An expert by experience is a person who has personal experience of using care or caring for someone who uses this type of care services.

Before the inspection we looked at the information we already held about the service. We reviewed previous inspection reports for this service. We also reviewed notifications, safeguarding alerts and monitoring information from the local authority. We spoke with the local authority commissioning and adult safeguarding teams. The local authority also had concerns about the service and have been monitoring and working with the service provider to improve the quality of care provided. Many of the concerns we found during this inspection reflected the same concerns raised by the local authority staff who had visited the service since our last inspection in October 2013.

During the inspection we spoke with seven people who used the service and six relatives. We spoke with 19 members of staff including the regional manager, the registered manager, a peripatetic manager, the clinical lead, two unit sisters, two nurses, three senior health care assistants, three health care assistants, two activities workers, two administrators and the chef. We looked at 19 people's care files, 12 staff files, staff duty rotas, a range of audits and feedback, various meeting minutes, maintenance logs, incident and accident log, safeguarding records, activities timetable, food menus and policies and procedures for the home and other documents relevant to the management of the service. We observed care and support in communal areas and also looked at some people's bedrooms and bathrooms, with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People had mixed views about feeling safe at the home. One person said, "I do feel safe. The building is designed to be safe." However, another person told us, "I do not always feel safe." Staff told us they had a responsibility to report on any physical injuries or concerns they had about financial abuse. The home had a safeguarding adults policy which was robust and staff knew who concerns should be reported to. The investigation and onward reporting of safeguarding concerns was the responsibility of the clinical lead. Records showed that not all incidents had been reported as safeguarding concerns including 31 unexplained injuries and four incidents where residents harmed each other. During our inspection we discovered an incident of neglect where a failure to monitor someone's health had led to the development of skin condition. We requested this be raised as a safeguarding alert. This was completed, however, the description of the incident related to the physical harm caused to the person and did not identify a type of abuse as required by the form.

Staff files showed that not all staff had training in protecting people from harm. When asked about their role in safeguarding one member of staff said, "I don't really know." When this was explored further they demonstrated they knew the indicators of abuse and would report it on. None of the staff we spoke with during the inspection identified neglect as a type of abuse. This means that people were not protected from avoidable harm and abuse as reports and investigations did not always identify the risk of abuse and staff understanding of abuse was limited.

The above is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some risk assessments were well completed with a good level of personalisation and detail. For example, one plan gave details of how to support someone in using a hoist to transfer and gave topics of conversation that would help the person to calm down. However, most files contained insufficient information on how risks to individuals were managed. For example, one person's risk assessment stated they, "sometimes need the assistance of two care staff for personal hygiene needs depending on her mood." There was no information for staff to use to identify situations where two staff may be required and no detail about how this support would be provided. There was no information about what type of mood this meant and what the indicators of this might be.

We saw that one person displayed behaviour that was challenging to the service and they became verbally aggressive to staff. Staff were able to support the person to calm down, however, the person's care file contained no behaviour management plans and the only risk assessment available related to a risk of poisoning. We asked for this person's risk assessment to be updated in light of the risks to them, other residents and staff. The updated risk assessment said that staff should "show empathy and concern" and "show that you care and you can understand his frustration." Staff were instructed that "needs must be identified" but there were no details on how they might go about this or how to approach this person when they were in distress. These are not appropriate measures to mitigate the risk of harm to the person or others.

Records showed that the home used a risk assessment tool to identify who was at risk of skin breakdown and pressure wounds. The associated risk management plans were inconsistent. Two people who were identified as being at a similarly high risk with similar risk factors such as limited mobility, poor diet and continence issues had very different risk management plans. One person had pressure relieving equipment including a specialist mattress and cushion with a re-positioning timetable in place but the other did not. Re-positioning instructions for staff were not detailed and provided minimal guidance. Plans told staff that people should be re-positioned "frequently" but there was no information about what frequently meant. Some people who had been identified at high risk of developing pressure wounds did not have any preventative measures in place. This means the service was not managing risks to individuals and the service and people were not protected from harm.

Risk assessments in individual files were limited to moving and handling, nutrition and skin integrity. There were no individual fire evacuation risk assessments so staff had no information on how to support people in the event of an emergency evacuation. The home had a central fire safety policy which staff were meant to sign to show they had read it. It has last been signed in September 2014.

Inadequate

Is the service safe?

The home had a robust medicines policy and clearly designated staff to administer prescribed medicines. Staff who administered medicines described the process of administering medicines correctly and were able to explain what actions they would take if they discovered an error. Records showed that 64% of staff completed training on administering medicines though nursing staff informed us that there were no competency assessments of staff. This was brought to the attention of the regional manager who informed us these would be introduced immediately. Medicine stocks were checked and audited in line with the policy and we found the amount of medicines matched the records. The home administered controlled drugs. The administration of controlled drugs is strictly regulated to ensure the safety of patients. On the first day of our inspection we found controlled drugs were not being administered in accordance with controlled drugs guidance. We found that the controlled drugs had been drawn up and were on the trolley during the medication delivery round. Two people are required to observe the preparation and administration of controlled drugs from start to finish and the signature in the book is to confirm that the process has been witnessed by both staff. There was already one signature in the controlled drugs book. When prompted by a member of the inspection team, the nurse called over a second nurse to observe the administration of the controlled drug. The nurse told us that the person "Would be able to taste if it had been tampered with." This is not an appropriate control measure.

The home's policy stated that people would be supported and encouraged to self-administer their medicines where they had the capacity and wish to do so. Records showed that none of the residents self-administered their medicines despite there being no indication of any reason why this would not be possible in their records. There were no medicines risk assessments relating to self-medication in any of the files viewed. We asked a nurse why no one was self-administering and we were told, "They are old." This is not an appropriate reason.

People had a drug therapies and medication needs section in their care files. This detailed the medicines they were prescribed on their admission to the home. Care records showed a list of medicines had not been updated and the care plan related to how the person was supported with receiving medicines. There were no individual medicines risk assessments and no information about side effects of medicines was included in individual files. The up to date list of which medicines a person was prescribed was kept in the medication administration record (MAR) folder which was stored centrally. The application of prescribed topical creams was delegated to care staff providing personal care. The staff recorded this in the MAR chart, however, on the first day of our inspection nursing staff made this record without checking whether or not care staff had administered the cream as prescribed. Care staff did not have access to the MAR chart and topical prescriptions were recorded in a separate file in people's rooms. Information in these files did not always match the prescription information in the MAR chart. One person had been prescribed five different topical medicines but only two of these had been recorded in the file in their room. This means they had not been receiving their medicines as prescribed. During our inspection we found that this person had developed moderate to severe dermatitis which the care assistants had been recording as "scratches on body" since August 2015. After we brought this to the attention of staff this person was seen by a GP.

Some people were receiving their medicines covertly. This means they were not aware that they were taking medicines as they were being disguised by staff. Records showed that appropriate capacity assessments had been conducted and a best interests decision had been made with the GP and relatives involvement as appropriate and that reviews of these decisions were conducted regularly. However, instructions on how the medicine should be prepared for covert administration were not always available. On one person's file there were no instructions and staff were crushing a medicine where this was not safe to do. This was brought to the attention of nursing staff who secured a prescription for an alternative.

The service had completed a health and safety audit in March 2015. Records showed all risk assessments should have been reviewed but had not been. Records showed that health and safety checks including water temperature checks, flushing the taps of empty rooms, extraction and ventilation checks, the nurse call system checks and the weekly maintenance checklist had last been completed in August 2015. The registered manager informed us that the maintenance position was vacant and the provider was providing cover for emergency maintenance work only.

Inadequate

Is the service safe?

This means the routine checks required to ensure the safety of the premises and equipment were not taking place, putting people at risk of harm of unsafe premises and equipment.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a robust recruitment policy in place. Records showed that the service checked people were suitable to work in care through checking employment references and completing a criminal records check. We found that one person had provided references that pre-dated their interview date and these had not been verified. Another member of staff, employed in clinical role, had provided no clinical references. These issues were brought to the attention of the regional manager who took immediate action to seek references. The provider used an external service to check that staff were eligible to work in the UK. **We recommend the service seeks and follows best practice guidance on the checking of employment references.**

The home used a dependency tool to calculate the staffing levels required in the different parts of the home. Staffing levels were maintained at this level through the use of agency staff which was high at the time of our visit. On one unit half of the care assistants on duty were from an agency. Our observations did not reveal any concerns about staffing levels, though people, their relatives and staff felt the service was short on staff. One person said, “I don’t think there are enough staff. They are so busy all the time.” Relatives also expressed concern about staffing levels. One said, “Sometimes I do not think there are enough staff, especially at weekends.” Another said, “There could be a little bit more staff.” They were concerned that their relative had to wait for extended periods of time for personal care and this put their health and dignity at risk.

Inadequate

Is the service effective?

Our findings

Staff files showed new staff completed a three day induction and staff described this in detail. The service delivered a peer led training called resident experience and this was highly praised by staff who said it was very helpful in developing their understanding of what it was like to receive care. Records showed that a member of staff who began their employment in May 2015 had completed none of their formal training prior to the inspection team raising this as an issue. Records showed that completion of training varied across the service with an overall score of 54% of training required completed.

The service had a policy which stated staff should receive a minimum of six supervisions per year. Complete records of supervisions were not available during the inspection as the registered manager was on leave and the staff in charge could not access the records. Some staff told us that supervision was supportive and helped them to develop. One member of staff said, "It's useful to see how to correct your work." Other staff told us that supervision was not supportive and was used to tell them off. One member of staff told us they happened, "If you're seen making a mistake or a complaint, but not if you're good at your job." Another said, "I feel it's just to fill in the paper. Nothing happens and I don't feel supported."

Staff expressed concern that agency staff did not receive an induction into the service as they did not feel agency staff were able to participate as full team members as lack of induction meant did not know the residents or record keeping systems. Staff received training in core areas including, moving and handling, safeguarding, infection control, health and safety and fire safety. One member of staff said, "It would be nice if there was a bit more [training]." Another staff member said that following training in the Mental Capacity Act (2005) (MCA) they were "Not confident" in its application. Another said there had been no support or training for them to develop their skills following promotion to a more senior role in the organisation. Staff with line management responsibility told us they received no training in how to manage staff. One person's care plan included that they required staff to use physical intervention to support them with personal care. The plan stated that staff had received training in physical intervention however records showed this was not the case. This means the service was not ensuring that staff had the knowledge and skills they required to carry out their roles and responsibilities.

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

Records were inconsistent regarding people's capacity to consent to their care and treatment and staff showed a mixed understanding of when to seek consent from people. When asked when they needed to seek consent from people one nurse told us, "To take their picture and the flu jab. Not for medication every day, only for picture and flu." Other staff told us they sought consent for all care tasks they performed. Each care file contained a section called Rights, Consent and Capacity. In some files this was well completed and included details of fluctuating capacity and how to encourage people to be involved in decision making. However, in other files the information was conflicting, confusing or inappropriate. For example, one person was assessed as lacking capacity with the reason being that they had advanced dementia, later in this person's plan it stated that they, "Cannot string a sentence together." This person was receiving their medicines covertly, this had been assessed and recorded. However, the care plan stated "Staff should respect [person's] decision on how [they] likes to take [their] meds." This was a conflict with the actual process as medicines were administered without her knowledge or consent. Another person was assessed as having capacity but records showed that their relative was consulted on all decisions relating to their care and treatment. When this was discussed with staff they said this was because the relative became aggressive if they were not involved. There were no records showing whether or not the person wished for their relative to be involved in decision making about their care. This demonstrates a lack of understanding of the principles and application of the Mental Capacity Act (2005).

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

Staff told us they had received training on The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Records showed 17% of staff had received training on the MCA and 63% on DoLs. MCA and DoLS is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests. Many people living at

Inadequate

Is the service effective?

the home had DoLs authorisations in place. Records showed that the service had followed the correct procedures in seeking these authorisations. However, they also have a duty to inform CQC when authorisations to deprive people of their liberty have been granted. The service had not been doing this. When this was brought to the attention of the management 29 notifications were submitted. In addition registered persons are required to notify CQC of incidents, deaths and safeguarding alerts. These had not been made as required.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Care plans contained a nutritional profile for each person which recorded the person's likes, dislikes, allergies and special requirements. The chef held a copy of this. The chef wrote menus on a four-weekly basis adjusted for the seasons to ensure fresh vegetables could be used. Staff told us they used a pictorial menu to support people to choose their meals, however, these were not available in the service at the time of our inspection. People were offered asked the evening before their menu choice for the next day. The chef informed us, and we observed, this was used as a guide for numbers as many people were living with dementia and did not always remember the choice they made the night before. People were shown what food was available and made their choice again at meal times.

Religious diets and specialist diets were supported. All the food was prepared in a diabetic friendly way, with additional sugar added when the food was served for those who wanted it. Feedback from people and their relatives was mostly positive about the food, although one person did raise that they had been promised they would be provided with culturally specific food and this had not happened. Records showed that food and menu choices were discussed at both residents and relatives meetings. Observations showed that people were supported to eat and drink in a sensitive way when required. However, all meals were served at the same time and people were supported to eat in turn. This meant the food of those who were supported later on was not kept warm until they were ready to eat.

The home had strong links with the local health team. The GP visited twice a week and the service made direct referrals to tissue viability and district nursing where required. Staff had good links with health professionals and made relevant referrals to speech and language and mobility services. People's health needs were recorded in their care plans and advice from health care professionals was also recorded. These were cascaded to staff through daily handovers. We talked to visiting health care professionals who told us they were satisfied that staff in the home followed medical advice.

Requires improvement

Is the service caring?

Our findings

Relatives told us they thought that the staff were caring and had built up good relationships with people. One relative said, "We are like family. My [relative] gets spoiled and they support the whole family." Another relative said, "They seem to know what everyone wants. They sit with people. They'll give my [relative] a little touch and check if [they're] alright." Another relative told us, "[my relative] is very well cared for."

Staff told us they used a combination of the information in people's care plans and spending time with people to build relationships with them. One member of staff said, "I like them to tell me. I like to spend 20 minutes a day with people. I go to each resident and ask how they are." Another staff member told us, "Everybody is a somebody" and this guided how they got to know the residents. The senior care assistants in the two residential units showed empathy in terms of how people might be feeling when they arrived at the home and how this guided their initial interactions with people. One staff member said, "You have an interaction, you welcome them. They can be scared so you talk to them, sit by them. Understand their experience and background. It's a huge change for people, definitely I would panic if I were them."

Staff knew about people's cultural backgrounds and told us how they supported them in the home. For example, one person's religion meant that they did not listen to music and staff ensured that music was turned off when they were in shared areas of the home. The activities co-ordinators told us they celebrated religious festivals in the home. Staff told us how they promoted people's dignity through ensuring their privacy during personal care. For example, one member of staff described how they prompted someone for personal care using subtle non-verbal clues such as holding gloves as the person became distressed if they thought other people noticed they needed personal care.

Information about people who identified as lesbian, gay, bi-sexual or transgender (LGBT) was recorded in people's care files. However, one staff member told us, "We don't have anyone like that here." Another staff member said, "We don't have [anyone who identifies as LGBT]. We know because most have family." Records showed that only 56% of staff had received training in equality and diversity and this was reflected in the language staff used when discussing LGBT residents. **We recommend that the service seek and follow good practice guidance on supporting people who identify as LGBT in care homes.**

Care files had a section for end of life care wishes to be recorded. This was blank in all the files viewed, even when people had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders. DNACPR orders are put in place when people, and their relatives and representatives depending on their individual capacity, agree that the person will not receive CPR to sustain their lives. Staff told us that end of life care needs were not discussed with people and their relatives until the medical advice was that the person was in the last days of life. This means that people did not have the opportunity to plan their deaths. Staff told us these conversations were, "Very difficult." Another staff member said, "It's a very difficult thing to talk about." Staff were not confident in the application of DNACPR orders, one nurse told us, "We have some who say they want to stay here, but their family will request they go to hospital." Another member of staff told us, "We have to send them to hospital, we might get sued." This means that even when people have expressed their wishes regarding their death, the home is not always respecting them. We recommend that the service seeks and follows good practice guidance on supporting people at the end of their lives. **We recommend that the service seek and follow good practice guidance on supporting people at the end of their lives.**

Inadequate

Is the service responsive?

Our findings

People and their relatives gave us mixed feedback about the activities provided by the home. One relative said, "They are always doing activities, but my relative doesn't join in." Another relative made a similar point saying, "There is no activity he can do here." People told us what activities they would like to do. One person said, "I like opera and they know that. If I could see or hear opera I would be very happy." Another person who did not leave their room indicated they were bored and would like somebody to do things with them. The home employed activities staff who facilitated group activities in the different units each day. We observed a film, music sessions and arts and crafts during our inspection. One of the activities staff told us they aimed to see people who could not leave their rooms once a month. The home has a plan to recruit a further activities worker to support people who cannot join in group activities.

The quality of care plans varied across the home and was notably more person-centred in the residential units. In the nursing units plans were more task focussed. In one of the residential units plans contained good information about how people wished to be supported and their voice was included in the plan. For example, one plan stated that if the resident became distressed staff should "Quietly and calmly discuss about [their] children and other people [they] like to talk about." In one of the nursing units one person was described as being able to weigh information, however their care plan stated, "This care plan is written in agreement and collaboration with the care staff and [person's] family." There was no evidence of the person's voice in the plan.

Care plans were reviewed and updated at least annually, and on some units this was done monthly. However, it was not always clear when plans had been updated as in some cases the care plan documents were being used to record daily care. In addition, changes in needs and support were not always captured in the care plan reviews. For example, health related aspects of plans did not contain updates on medicines or feedback from health professionals. There were inconsistencies within care plans and a lack of clear information for staff on how people liked and needed to be supported. For example, staff were instructed that they "Need to anticipate [person's] daily needs" but were provided with no guidance on how to do so. One plan identified that the person was unable to use the call bell to request help but provided no information about how the person might indicate they wanted support and no information on how frequently staff should check on their welfare. These issues were being addressed by the service. The service was implementing a training programme for all staff involved in care planning to support them to develop their skills in writing and updating care plans. However, this training programme had been instigated after staff had started updating care plans onto new documentation. This meant that some of the new documentation would need to be repeated as the information contained remained task focussed and lacked the person's voice.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was in the process of completing short profiles of each resident with a photograph and detail about their preferences for each person's bedroom door. The completed work looked gave a snapshot of the person in an accessible and person centred way. For example, one person's portrait showed a picture of them when they were young and gave details of their significant relationships, work history and interests.

The service had a complaints policy which was on display in the reception area of the home. It included clear timescales and information on how to escalate concerns if people were not happy with the response. The service had introduced an electronic feedback system within the home where people could complete feedback surveys on an electronic tablet. Six relatives and three people who lived in the home had completed a feedback survey between July and October 2015. The relatives were satisfied with the service their relatives were receiving and no actions were required. However, the residents were less satisfied and only 50% felt that they were treated with respect, involved with their care, and felt safe. The action resulting from this feedback was that food, care plans and clothing was discussed in the residents and relatives meetings.

The home held regular relatives and residents meetings to discuss issues at the home. Records showed these had been used to update people and their relatives about what was going on at the home and changes in management and staffing. Relatives had raised concerns and records showed that the registered manager had investigated these. One relative told us they had made a complaint

Inadequate

Is the service responsive?

about the behaviour of a member of staff and that the registered manager had dealt with this. They said, “We had a meeting where I brought it up and it was dealt with. The manager was fantastic.”

Inadequate

Is the service well-led?

Our findings

People and their relatives gave positive feedback about the registered manager. One relative said, "She's getting things sorted out. Her door is always open." Another relative described her as "Approachable, I would know where to go if there was anything I didn't feel comfortable about." A third relative said, "The manager is very nice and approachable." This contrasted with the feedback from staff who told us they felt the registered manager spent all her time in the office and did not spend time getting to know the staff and people living in the home.

The registered manager registered with CQC in October 2015 having started at the home in July. Prior to their appointment the home was without a manager for seven weeks after the previous registered manager left abruptly. During those weeks the deputy manager at the time managed the home. The lack of management support to the current management team was raised by staff and external healthcare professionals and the local authority. One healthcare professional said, "The corporate team is invisible." The local authority had also expressed concern regarding the support available to the management of the home. Staff expressed concern that the registered manager needed support to manage the home. One member of staff said that the provider "Did not want to invest" in the service.

The home was going through a period of significant change and the registered manager had taken firm disciplinary action on her arrival and several staff were dismissed. However, staff felt that they were unsupported and overworked. One member of staff said, "They treat us like slaves." Another staff member said, "Management is not supportive." Several members of staff raised that both the registered manager and regional manager spent most of their time in the office and this meant they were "Invisible" to staff on the units. One member of staff said, "I don't think they know what is happening on the units." All the staff we spoke to expressed their concerns that the staff team were very unhappy and that many staff were leaving the home. One staff member said, "The unit is crying, the staff are in agony." Though some staff told us they felt staff worked together as a team, other staff felt that there were unfair divisions of work between nursing and non-nursing staff.

Several staff told us they did not like to work on one of the units because all the tasks were delegated to the care assistants and the nurses did not provide additional support when needed. There was an unhappy, task focussed culture at the home.

The provider had a system of daily, weekly and monthly audits that involved talking to residents and staff and auditing files. The daily checks involved checking the cleanliness of the home, the presentation and wellbeing of residents, checking a single care file and commenting on the atmosphere of the home. The summary of daily checks showed the service achieved an overall rating of 96% good scores. The provider also had a more detailed audit that was completed weekly which involved an in depth assessment of care files and interviews with residents and staff. Records showed sections of this audit had not been completed properly. Large sections of the audit, including the sections relating to needs assessments, care plans and risk assessments had been marked as not applicable in all audits. In addition, the audit showed that 38% of residents whose files were audited lacked capacity to consent to residence and care yet the question relating to capacity assessments was recorded as being not applicable in 95% of audits. The audit recorded that 100% of files showed a care plan which identified self-medication or a detailed medication care plan and that 90% of files had a moving and handling plan in place which clearly identified how the resident mobilised both in and outside the home. We found this was not the case during our inspection. The audit identified that 57% of files reviewed did not have a plan which identified how residents communicated their choices and needs. This had not been addressed. This means that the management systems in place to ensure the quality of care were not effective.

The management audits had failed to identify that notifications to the Care Quality Commission had not been made. In addition, the management checks on routine maintenance had not taken place since August 2015. This means that interim measures to ensure the safety of the service had not been put in place. It had not been identified that the checks were not being completed.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.