Aegis Residential Care Homes Limited

The Old Vicarage Care Home

Inspection report

15 Naze Lane
Freckleton
Lancashire
PR4 1RH
Tel: 01772 635779
Website: www.pearlcare.co.uk

Date of inspection visit: 8th & 13th October 2015
Date of publication: 06/01/2016

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
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

The Old Vicarage is a residential care home accommodating a maximum of 31 older people including older people who live with dementia. Accommodation is provided on two floors. A passenger lift is available. There are several communal lounges, a separate dining area and an enclosed garden. The last inspection of the service took place on 5th December 2013. During that inspection the service was found to be compliant with all the area we assessed.

The inspection took place on the 8th and 13th October 2015 and was unannounced.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available during the inspection due to a period of extended leave. There were temporary management arrangements in place at the time of the inspection.

Summary of findings

We found that risks to the health, safety and wellbeing of people who used the service were not consistently well managed. Staff were not always aware of the risks to people they were supporting. In some cases, we found risks had been assessed but information was out of date and did not reflect people's current circumstances.

The support of people who did not have capacity to consent to some aspects of their care was inconsistent. The service did not always work in accordance with the Mental Capacity Act or Deprivation of Liberty Safeguards, which meant people's rights were not always protected.

Processes for planning people's care required improvement to ensure that people were provided with care that met their individual needs and was in line with their personal wishes and preferences.

Arrangements for the safe management of people's medicines were not effective. This meant that people were not protected against the risks of unsafe medicines practice.

Infection control practices required improvement to ensure that people who used the service were protected against the risks of infection and were provided with clean, comfortable accommodation.

Recruitment practices were inconsistent and pre-employment checks, required to protect people who used the service, were not always completed. Not all staff felt they had been provided with adequate training and support to carry out the duties expected of them. The induction of new staff was inconsistent and did not ensure they were fully equipped to carry out their roles.

The processes in place to monitor safety and quality across the service were not being effectively utilised at the time of the inspection. An audit schedule was in place but had not been completed for some time. This meant that some areas in need of improvement had not been identified, for example, medicines management.

We received some positive feedback from people who used the service, their relatives and five community professionals. People spoke highly of carers describing them as patient and helpful. People told us they found staff and the acting manager to be supportive and approachable.

People told us they knew how to raise concerns and that they would feel comfortable in doing so.

We saw there were processes in place to determine staffing levels and ensure they were in line with the needs of people who used the service. The acting manager was able to give us examples of increases in staffing levels, which had been arranged in response to changes in people's needs.

We found the service to be in breach of several regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment including medicines management, obtaining vaild consent, person centred care, safeguarding, staff recruitment and governance.

You can see what action we have asked the provider to take at the end 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?

Inadequate

The service was not safe.

Risks to people who used the service were not always identified or consistently well managed.

Arrangements for the safe management of medicines were not effective. This meant that people were not protected from the risks of unsafe medicines practice.

The recruitment of new staff was inconsistent and did not always include thorough pre-employment checks. This meant people were at risk of receiving their care from staff who did not have the suitable skills, knowledge or character.

Is the service effective?

Requires improvement

The service was not consistently effective.

There were inconsistencies in how people's mental health and ability to consent to their care was assessed. Not all staff had a good understanding of the legal requirements of the Mental Capacity Act 2005.

Staff did not receive consistent training and support to equip them to carry out their roles effectively.

Is the service caring?

Requires improvement

The service was not consistently caring.

Some people expressed satisfaction with the attitude and approach of care workers and we saw that people's privacy and dignity was promoted.

We observed that staff did not always communicate well with people and opportunities for positive social interaction were sometimes missed.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Arrangements for care planning and review were inconsistent. People's care plans did not always provide a clear up to date picture of their care needs.

People who used the service and their relatives felt able to express their views and ideas.

Summary of findings

Is the service well-led?

Requires improvement 

The service was not consistently well led.

People had been kept up to date with changes in the management of the service, to as great an extent as possible.

The processes in place to monitor safety and quality across the service were not effective. This meant that some areas in need of improvement had not been identified, for example, medicines management.

The Old Vicarage 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.

The inspection took place on the 8 & 13 October and was unannounced.

The inspection team was made up of two social care inspectors 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. This expert had experience in caring for someone who used services for people who lived with dementia.

Prior to our visit, we reviewed all the information we held about the service, including notifications the provider had sent us about important things that had happened, such as accidents. We also looked at information we had received from other sources, such as the local authority and people who used the service.

We spoke with four people who used the service during our visit and three visiting relatives or friends. We also had discussions with the acting manager, acting deputy manager, provider and six care workers. We had feedback from five community professionals during the inspection and also contacted the local authority contracts team.

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.

We closely examined the care records of five people who used the service. This process is called pathway tracking and enables us to judge how well the service understands and plans to meet people's care needs and manage any risks to people's health and wellbeing.

We reviewed a variety of records, including some policies and procedures, safety and quality audits, three staff personnel and training files, records of accidents, complaints records, various service certificates and medication administration records.

Inadequate

Is the service safe?

Our findings

Most people we spoke with told us they felt safe living at The Old Vicarage. One person described how risks to their loved one's safety in relation to falling were, in their opinion, managed well. They told us that staff monitored their relative closely through observation and the use of a pressure mat.

When viewing people's care plans we saw some examples of risk assessments in areas such as falling, nutrition or developing pressure sores. However, we found evidence that some risk assessments were not accurate and did not fully reflect the person's circumstances. For example, we found one risk assessment for moving and handling, which stated the person 'used a zimmer frame for all transfers and walked well.' However, we observed during our visit, that the person struggled to stand and walk and needed to be supported with the use of a wheelchair.

On two separate occasions, we observed people using Zimmer frames, which were labelled with other people's names. This was potentially unsafe as the frames may not have been suitable for them. On both occasions, care workers were in a position to have noticed this and rectify it.

We looked at the care plan of another person who was staying at the home on a short term basis. We noted there was no risk assessment in place for falling. This was of concern, as it had been established during the pre-admission assessment, that this person was known to be at risk of falling. In addition, the person had experienced a fall at the home since his admission.

We looked at the plan of another person who had recently come to stay at the home. In discussion, staff described this person as having some complex behaviours, which could be a risk to themselves and those around them. However, none of this information had been noted in their care plan and there was no information for staff about how to keep the person safe.

These findings demonstrated a breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We identified concerns about the way people's medicines were managed. We looked at medicines that were in use and found they were not always stored safely. We found an ointment, which should have been stored in the fridge, but was being kept in the medicines trolley. As the ointment had not been stored properly it was not safe for use. We also found a bottle of liquid medicine, which had leaked into a carrier bag over other tablets. Eye drops were in use which had been opened for longer than the recommended time of 28 days and there were three bottles of antibiotic liquids in the fridge, which were no longer in use. We also found two tubes of cream, which were confirmed as being in use but had no names on.

Some medicines records were incomplete and unclear. We saw several hand written medication administration records (MARs), which had not been witnessed or countersigned and contained basic errors or omissions, such as dosage or times of administration. Several people's records did not have clear instructions about administration, photographs, or other important information such as the person's allergy status. Which put people at risk of not receiving their medicines as prescribed.

Some people were prescribed medicines on an 'as required' basis. There were some examples where clear information about when these medicines should be administered was not provided. We also found there was a lack of information about some people's topical medication, such as creams or ointments.

We looked at the MAR for one person, who was staying at the home on a short term basis. We were concerned to find this person had not received her medicines for several days, as according to her records, she had refused them. However, this issue had not been followed up and there was no evidence that any action had been taken to safeguard the person from the potential risks of not having their prescribed medicines. One of the medicines the person had missed for several days was an antidepressant, and on the day of the inspection, we noted their daily care records described them as weepy.

We cross checked several tablets against records and in some examples found the amounts in stock to be incorrect. This meant that on some occasions, staff had signed to say they had administered medicines but had not.

These findings demonstrated a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

We carried out a tour of the home viewing all the communal areas and a selection of people's bedrooms. The environment appeared to be generally clean. However, some areas of the home were malodorous, the main communal lounge extremely so. The acting manager had taken steps to address this issue by the second day of the inspection by replacing some of the flooring.

Infection control procedures were in place but we observed some practices, which were not consistent with them. For example, we observed one person who used the service handing out biscuits to others without first being supported to wash their hands.

Staff confirmed that PPE (personal protective equipment) was always available when required and a relative we spoke with confirmed that staff used PPE when providing personal care to their loved one. However, hand gel was not seen in any of the communal areas or people's bedrooms and staff we spoke with confirmed they did not carry it on them.

Cleaning schedules were in place and checks were conducted to establish they had been completed. However, in viewing the checks we noted that the issue of malodour had not been identified at any time. This indicated the checks were not carried out effectively.

We confirmed that a full infection control audit had not been carried out since May 2014. This meant that no formal checks had been made in relation to infection control practice and opportunities to make improvements to practice had been missed.

These findings demonstrated a breach of regulation of regulation 12 (2)(h) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During the tour of the home we noted some avoidable hazards in the environment which presented risks to the health and safety of people who used the service. We saw there was a stairgate fitted to the bottom of a stairway on the ground floor of the home. This was left open all day, held open by another door. In a small fire exit corridor, we saw wheelchairs were stored, which partially blocked the exit route. This was in contravention of a notice on display in the area stating the exit should not be blocked.

In one area we noted some carpet stuck down with tape. The tape was worn and curling and presented an unnecessary trip hazard.

We noted that several of the doors within the home 'slammed' shut. This was making one person who lived at the home quite anxious and also created a risk of harm due to potential entrapment of limbs.

The above findings demonstrated a breach of 12 (2) (d) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the personnel records of two members of staff who had been recently appointed. We found that recruitment procedures were not consistently followed. An application form had not been completed by one member of staff and no references had been sought for them. This staff member had also commenced work at the service prior to their DBS check being received, which is a check required for all staff, to show if they have any criminal convictions or have ever been barred from working with vulnerable people.

There was a partly completed application for the second staff member as well as two written references. However, the reference letters sent to this person's referees did not include the prospective employees' name, and therefore we could not establish if the references received by the home were authentic.

The failure to follow thorough recruitment procedures meant that people were at risk of receiving their care from staff who did not have the suitable skills or knowledge to care for them in a safe manner, or who were not of suitable character.

These findings demonstrated a breach of regulation 19 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager advised us there was a process in place to assess staffing level requirements and was able to provide us with evidence that staffing levels were reviewed on an ongoing basis. We also noted examples where staffing levels had been increased in line with changes in people's needs.

The service had a safeguarding policy and procedures in place, which included guidance for staff on how to raise concerns they had about the safety and wellbeing of people who used the service. We also noted that training on safeguarding was provided to all staff as part of the service's mandatory programme.

Inadequate

Is the service safe?

Staff we talked with demonstrated a good understanding of safeguarding procedures and were able to correctly describe the action they would take if they had any concerns that a person was at risk of abuse.

However, when viewing people's care files we found that each person's file contained a statement which read: 'The staff in this home can be over familiar with myself; excessively friendly and informal. (This does not constitute abuse in anyway).' This was highly inappropriate and not in accordance with people's rights. Following discussion with the acting manager, who was not aware of this paperwork, agreement was reached that it would be removed immediately.

Requires improvement

Is the service effective?

Our findings

People we spoke with expressed satisfaction with the support they received to access health care services. One relative was particularly complimentary and told us they felt the care staff were good at recognising if her family member was unwell and said they always took the appropriate action.

One community professional we consulted commented that the staff at the home acted appropriately and requested healthcare advice when necessary. However, another community health care professional expressed some concern about communication within the service. They had visited the service on some occasions and found some care workers had not been updated about changes in the health of the person they were visiting.

The records we saw showed that a range of community professionals were involved in the care and support of those who lived at the home, such as dentists, community nurses, GPs, opticians, audiologists and the mental health team.

A personal care plan within people's care files contained details about their prescribed medication and their medical history, so that important information was readily available for paramedics and medical staff, should a transfer to hospital be required.

We looked at how people were supported to maintain safe nutrition and hydration. A risk assessment was in place for each person, which assessed their risk of becoming dehydrated or malnourished. We saw that measures were in place to control any risk identified, such as monitoring people's weight and food and drink intake. However, several care plans we read contained a statement; 'We have carried out a data analysis today, which indicated [name removed] is at very high risk due to his dementia, previous stroke, skin and age, so requires no further input.' We discussed this with the acting manager who was not aware of the statement or what it meant. It appeared whoever wrote this statement did not understand what they were writing and it was of concern that staff may read the statement and not take any further action in response to people's nutritional risks.

People were weighed on a monthly basis, or more frequently if needed. Records were seen of this. The records of one person showed she had been weighed each month and had lost four Kilograms in five months, but there was no indication of this weight loss being followed up.

The care plan of one person showed that she disliked most vegetables and that she required cutlery with large handles when eating her meals. We visited this person during lunch and one of the inspection team dined with her. Standard cutlery was provided. The meal she was given, contained mushrooms and cabbage, both of which she said she did not like. She sent the meal back to the kitchen and requested an alternative. She was then presented with a beef dinner, which she was unable to eat as she found it too tough to chew, so returned that to the kitchen also. Eventually she was given a jam sandwich.

We asked one member of staff what was for lunch for the residents. We were told that it was mushroom and chicken pie. We asked what the alternative was and we were told that there was not one. The staff member stated, "That's what they are all having." This indicated people were not given a choice about what they had to eat. This was further supported by our observations at lunch time; When being served their meal, a number of people commented they did not like mushrooms. A number of these people sent their meals back unfinished but were not offered an alternative.

We received mixed responses about the standard and variety of meals provided at the home. One person said, "It is very ordinary, there is a predominance of beans on toast." Another having been served his meal said, "I don't reckon much to that dinner, it's a load of rubbish."

We noted that meals were served to male residents on large plates and smaller plates were provided to female residents. One person was served their meal on a side plate. We asked staff how portion sizes were determined and they advised us that the men liked bigger portions and the women smaller. There was no discussion with people as to the portion size they required, when we observed the lunch time service.

These findings demonstrated a breach of regulation 14 (1)(4)(a)(b)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that practice in relation to the MCA and DoLS was inconsistent. It was not always clear on people's care records whether valid consent for various aspects of their care had been obtained. Some consent forms were not signed and in some other examples, we found consent forms, which had been signed by family members, with no consideration being given as to whether this was legally valid.

The MCA code was not always followed in practice. In some examples there was no assessment of mental capacity and in others, there was an assessment, but it was not decision specific. The care records of one person showed they had been assessed by the DoLS team, but a DoLS approval had been refused because the individual was in the early stages of dementia and had the capacity to make their own decisions. A completed mental capacity assessment for this person was not present in their care file.

These finding demonstrated a breach of regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During a tour of the home we noted the presence of 'safety gates' on a number of people's bedrooms. In discussion we were advised that these were in place at the request of the people who occupied the rooms to stop other people who used the service going into their rooms uninvited. We were able to establish this was the case for one of the people and also that they were able to open the safety gate themselves. However, for another person, we could not establish if they were able to consent to the gate being in place and there was no information on their care plan as to whether this was a restriction of their freedom.

We heard from a family member that one person who used the service was being given medicines in their food as they had been refusing to swallow their tablets. This is known as covert administration. We looked at their care plan and found there was no formal best interest decision in place regarding the covert administration of their medicines. In addition, there was no capacity assessment and there was no evidence that the acting manager had considered whether the covert administration was proportionate or necessary.

Prior to the inspection, we were advised by a community professional that the service had unlawfully deprived a person of their liberty for several weeks. This was because they had failed to update an authorisation under DoLS, which had expired. This issue was investigated by the safeguarding authority and substantiated.

These findings demonstrated a breach of regulation 13 (5) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was a mandatory training programme in place, which all staff were expected to complete. This programme included a variety of courses including moving and handling, safeguarding and caring for people with dementia. An overall training matrix was not available to demonstrate the training completed by all staff. We also noted that a training audit had not taken place for some time. However, we were unable to establish how long this has been.

We viewed three staff personnel records and saw they contained certificates of relevant qualifications they had achieved, such as nationally recognised qualifications in social care and certificates in medicines management and safeguarding. However, certificates for other training in relation to nutrition and health, food hygiene and infection control were all dated 2011.

We spoke with one person who was newly appointed to the home. This person confirmed they had not received any formal induction but they were of the impression this was going to be provided.

Requires improvement

Is the service effective?

An agency carer was on duty on the day of the inspection. We asked the acting deputy manager about this person's induction and were advised there was no induction record completed. However, the care worker was not being shadowed or supported by any other staff members throughout the day.

We spoke with one staff member who advised that due to recent changes in the management team, some staff had been requested to take on some additional duties such as ordering medicines and monitoring medicines management. However, the staff member told us there had been no training provided to enable them to carry out the additional duties and said they felt, 'ill equipped.'

These findings demonstrated a breach of regulation 18 (1)(2)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People we talked with spoke highly of staff describing them in ways such as kind, caring and helpful. One person complimented the staff on the way they cared for their family member and described them as having a 'terrific amount of patience'.

We observed some positive interaction between staff and people who used the service throughout the inspection. However, we also observed some examples where there were missed opportunities for positive social interaction. At meal time little attention was paid to people's verbal requests and we observed some misunderstandings because staff did not take the care to ensure that they listened, rather than assuming what people had said.

One person was asleep in an armchair at the beginning of the meal, and we saw a staff member call his name a few times, then put an apron around his neck whilst he was still not properly awake, without asking permission. He was then left still leaning over the side of the chair looking unsupported and uncomfortable. Later, a meal was brought and left on his tray table with no cutlery. A staff member, some time later, went to sit with him and assisted him with his meal, sometimes speaking to him, but other times looking quite disengaged or talking with a nearby staff member.

We observed a care worker supporting someone to mobilise. The person being assisted was very anxious and frightened of falling. The care worker did not communicate well with the person and didn't seem to understand how to support them. This did nothing to alay this person's fear.

The plans of care we viewed included the importance of promoting privacy, dignity and independence. We noted that care workers addressed people in a respectful manner and those we spoke with felt their dignity and privacy was respected. We also noted that careful arrangements had been put in place on the day of our inspection, to ensure the dignity of someone who had passed away was respected.

The majority of people's care plans contained important person centred information such as their preferred daily routines. Details of how they wanted their care to be provided and the things that were important to them were recorded, which helped care staff to meet their individual needs and wishes. However, this information was not included in the care plans we viewed belonging to people staying at the service on a short term basis.

The care file of one person showed her religion on admission and this record stated, 'Attends church weekly'. However, there was no further reference to her religious needs or evidence to show that she was supported to follow her faith. A record of significant events in people's lives was maintained, but these details were brief. For example, one record simply stated, 'Wedding day' and 'Kids'. This document also recorded the names of family members, but failed to identify who these people were.

A poster was displayed in one of the home's communal areas about local advocacy services in the area. Staff spoken with were aware of the role of advocacy services and how to signpost people to them. The acting manager was able to provide evidence that she had suggested to one person who used the service that they request an external advocate and upon their agreement, had made the appropriate referral for them.

Requires improvement

Is the service responsive?

Our findings

We viewed a selection of people's care plans. We noted that in all but one example, an assessment of people's needs had been completed prior to them moving to the home. This meant that the acting manager could consider whether the person's needs could be properly met prior to offering them a place.

Some of the care plans contained good examples of person centred information and details of their individual preferences. However we also noted examples, particularly the care plans of people who were staying at the home on a short term basis, that did not include this detail. Most people's care plans contained an overview of the support they required on a daily basis.

We noted some examples where people's care plans were not followed in practice. For example, one person's care plan detailed some specific support they required at mealtimes. We observed the person at a mealtime service and saw this support was not provided in accordance with their care plan.

We requested the care plan of one person because we had found when looking at their medicines records, that they had refused to take them for several days. Staff were unable to produce a care plan despite several requests. We were eventually told one could not be found.

We looked at the records of another short stay resident. We found these to be of poor quality. This person did not have a full plan of care in place, only a 'short stay care plan.' We spoke with staff about this person's needs. We were told she had some complex needs which required careful management. However, there was no plan of care in place in relation to the management of the person's complex needs. We also noted there was no pre-admission assessment recorded. We were told such an assessment had been conducted, but not recorded. This person had lived at the home for one month.

The failure to ensure care plans were in place for all the people who used the service was of concern because this meant staff did not have the information they needed to care for people in a safe manner.

Not all the people we spoke with felt they had been given the opportunity to be fully involved in their, or their loved one's, care planning. One person told us they had been asked to provide some details such as likes and dislikes but felt there was additional important information that hadn't been discussed. Another person explained that the service had failed to meet their relative's preferences in the way their personal care was provided.

These findings demonstrated a breach of regulation 9 (1)(3)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A lifestyle questionnaire had been completed, which showed what leisure activities people enjoyed or had participated in during their lives. However, this information was not transferred to people's care plans.

We spoke with the activities co-ordinator who had carried out this role for several years. She advised us that she attempted to provide a varied activities programme that met the needs and suited the preferences of people who used the service.

We noted there was no information about activities for the week posted in the home and were advised there were usually posters on the wall but these had not been put up due to staff being very busy. We did observe plans for previous weeks. These were A4 pieces of paper which may have not been accessible for all the people who used the service.

We saw that activities such as quizzes, bingo, gardening and art and craft were held within the home and that musical entertainers visited on a regular basis. However, there were no specific activities in place designed with the needs of people who lived with dementia. The activities coordinator advised us this was an area she wanted to develop.

We noted in the communal lounge area that there was both a television and a radio on. It was difficult to speak with people due to the volume of noise and due to the two things being on at the same time, it was uncomfortable. We asked a staff member to turn one of the items off, to help ensure people were provided with an environment within which they could relax.

No one we spoke with was aware of any residents' or relatives' meetings. We were advised by the acting manager that these had not taken place for some time. The

Requires improvement

Is the service responsive?

acting manager advised us that individual meetings had been held with people who used the service and where relevant, their family members, about developments in the home but there were no records kept of the meetings.

Nobody we spoke with recalled any time that they had been asked their opinion, or asked if they had any comments or suggestions about the service. The acting manager advised us that she was about to conduct a satisfaction survey for people who used the service and their representatives.

The complaints procedure was clearly displayed within the home. The procedure provided information for people about how to raise complaints and how they would be dealt with by the manager and provider.

People spoken with were aware of how to raise concerns. One person commented that they didn't have any complaints but would be comfortable in raising them if they did.

Requires improvement

Is the service well-led?

Our findings

At the time of the inspection the registered manager was not available as they had been on a period of extended leave for several months. We were advised the regional manager for the organisation was overseeing the running of the home.

People we spoke with were aware of the temporary management arrangements and who they should speak to if they had any concerns. In addition, people felt comfortable to approach the acting manager and were confident any concerns they did raise would be addressed in an appropriate manner. A community professional commented that they found the acting manager very cooperative and helpful.

We were advised that the service had experienced some difficulties due to short notice, unexpected changes in the management team and that on this basis, processes in place to monitor the safety and quality of the service had not been completed at usual intervals.This meant that a number of audits in areas such as medicines management, care planning, infection control, recruitment and training had not been completed for several months. This information was supported by our findings, as we found a number of areas of concern.

These findings demonstrated a breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Prior to the completion of the inspection, the provider made arrangements for additional management support to be provided to the service by an experienced manager from a sister service. We were assured that the additional management support would be in place until the registered manager returned or was replaced.

Arrangements were also made for an extensive audit to take place with the assistance of representatives of the provider who were members of the organisational senior management team.

At the time of the inspection a review was underway of all the service's policies and procedures. It had been identified that some improvements were required and that some of the service's policies and procedures had not been updated in line with best practice. We were advised that this process was being completed as a matter of urgency, to ensure staff had up-to-date guidance in place, in relation to all aspects of the service.

Staff spoken with were aware of recent developments and felt they had been kept informed of issues affecting the service, to as great an extent as possible. Care workers told us they felt well supported and able to approach the acting manager with any concerns. Staff also expressed confidence in the acting manager to deal with any issues they did raise, in an effective manner.

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 9 HSCA (RA) Regulations 2014 Person-centred care 9. Person centred care. The registered person had failed to ensure that people's care was planned in a way that met their needs and reflected their choices and preferences. 9(1)(a)(b)

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11. Need for consent. The registered person had failed to ensure that valid consent was obtained from people who used the service for all aspects of their care. 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. Safe care and treatment. The registered person had failed to ensure that safe care was provided by assessing the risks relating to people's care and taking all practicable measures to mitigate such risks, including arrangements to ensure people providing care have the correct skills to do so. 12 (1)(2)(a)(b)(c)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. Safe care and treatment. The registered person had failed to ensure that adequate arrangements were in place for the safe management of medicines. 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. Safe care and treatment. The registered person had failed to ensure that adequate arrangements were in place for the safe detection and prevention of the spread of infection. 12(1)(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. Safe care and treatment. The registered person had failed to ensure that the premises were safe for the use of people who used the service. 12(1)(2)(d)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13. Safeguarding service users from abuse and improper treatment. The registered person had failed to ensure that lawful authority was obtained to deprive people who lacked capacity of their liberty. 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs 14. Meeting nutritional and hydration needs. The registered person had failed to ensure people's nutritional needs were safely met. 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18. Staffing. The registered person had failed to ensure that staff were provided with sufficient training and support to carry out their roles effectively. 18(2)(a)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed 19. Fit and proper persons employed. The registered person had failed to ensure that people employed at the service had the appropriate skills and were of suitable character. 19(1)(2)(3)

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 17 HSCA (RA) Regulations 2014 Good governance 17. Good governance. The registered person had failed to implement systems to effectively monitor the safety and quality of the service. 17 (1) (2) (a) (b) (e) (f)