Ringdane Limited

The Beaufort Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 16 November 2015 and was unannounced.

The Beaufort Care Home provides accommodation for up to 29 people who require nursing or personal care. Most of the people living at the home have complex medical conditions requiring a lot of care and support or highly specialised nursing. 11 were living at the home at the time of our inspection.

We last inspected the home in December 2014. After that inspection we asked the provider to take action to improve the management of medicines in the home. At this inspection we found improvements had been made but further improvements were still required.

There was no 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

Summary of findings

and associated Regulations about how the service is run. There was a peripatetic manager (a manager who provides support as required) who had been at the home for four weeks.

There had been no consistent management or clinical leadership in the home as the registered manager, deputy manager and the majority of the nursing staff had left the service. There was now a peripatetic manager in post, but it was clear they had limited knowledge of the medical needs of people living in the home or the skill sets of the staff working there. The majority of relatives were happy with the care provided, but expressed concern about the inconsistency of management. Staff were committed to providing a good standard of care, but did not feel valued and had not been kept informed by the provider of the changes within the service.

The home had been reliant on agency nurses to provide nursing care in the home. Although the provider had tried to ensure they used the same agency staff, people were not always provided with care by staff who knew them well. There was a concern that some people had been admitted to hospital because agency staff did not have the necessary skills to meet their needs and were not familiar with people's health history.

Permanent staff had received training required to undertake their work safely. We found they had not recently received sufficient support or supervision to help them work effectively. Nursing staff had not received clinical supervision.

We found the service met the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

Staff were kind and caring when providing personal care. However, staff interaction with people was mostly when supporting them with care tasks. We saw limited engagement between staff and people at any other time of the day. Relatives were not always confident their family member's dignity was maintained. Some relatives felt their family members did not receive the personal care required to promote their dignity.

People spoke highly of the activities co-ordinator, but there was little for people to do when the co-ordinator was not in the home. Some families were concerned their family members were left in their rooms a great deal which could lead to social isolation.

Care plans and assessments contained detailed information that supported staff to meet people's needs.

The provider and manager were responsible for completing a range of checks to ensure the quality of the service was maintained. These checks had not been completed consistently to identify when improvements were required.

You can see what action we told the provider to take at the back of the full version of the 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?

Requires improvement

The service was not consistently safe.

People did not receive consistent care from staff who knew them well because of the high use of non-permanent staff. People did not always receive care and treatment that met their individual needs and ensured their safety and welfare. Staff understood what action to take if they had any concerns people were being abused. People received their medicines as prescribed.

Is the service effective?

Requires improvement

The service was not consistently effective.

Permanent staff had received training to deliver effective care. However, they had not received the support they required to feel confident in their role and identify their developmental needs. Procedures were in place to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported with their nutritional needs and referred to a range of suitable healthcare professionals as required.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff were caring towards people and respected their privacy, but had limited opportunities to engage with people outside of delivering care. Staff morale was low and staff did not always feel they were kept informed about changes in the service. Some relatives felt anxious because the provider had failed to inform them about an infection outbreak in the home.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were positive about the engagement of the activities co-ordinator. However, when they were not in the home, staff had limited opportunities to provide social stimulation. People had detailed care plans to inform staff how to meet their individual healthcare needs. Care plans had not been consistently reviewed to ensure they were up to date.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager or deputy manager in post. A high turnover of nursing staff meant there was a lack of clinical leadership in the home. People and staff felt a lack of consistency in management had affected the quality of care provided. The provider had not kept people or staff informed about the changes in the home. Checks on the quality of care had not always been completed as required.

The Beaufort 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 16 November 2015 and was unannounced. The inspection was carried out by two inspectors, an expert by experience and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge of nursing. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service.

We reviewed the information we held about the service. We looked at information received about the home and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with local authority commissioners who funded the care for some people at the home. They told us they had identified some areas for improvement and were working with the home in relation to these.

During our visit we spoke with two people who lived at the home, nine relatives, three care staff, three nurses and two non-care staff. We also spoke with the manager and the area manager.

We observed staff interactions with people and the support they delivered in the lounges and dining area. We reviewed the care plans of three people. We also looked at other records such as medication records, recruitment files, complaints records and quality assurance records including meeting notes.

Requires improvement

Is the service safe?

Our findings

At our inspection in November 2014 we were concerned about the management of medicines in the service. During this inspection we found improvements had been made in the way in which medicines were managed in the home. However, further improvements were required to ensure people were protected against the risks associated with the unsafe management of medicines.

Medicines were stored safely and in line with legal requirements. We checked five people's medicine administration records and found people had been given their medicines as prescribed.

We found systems around the disposal of unwanted or wasted medicines to be disorganised. There were four books being used to record these medicines. We were told this was because agency nurses had not realised there was already a book in operation and had started new ones. Nurses were recording when and why they had given medicines that were prescribed 'when necessary' or 'as required', but were not always following the same system. Nurses we spoke with told us there could sometimes be confusion when there was a lack of continuity due to the number of agency nurses used in the home.

Relatives expressed no concerns about the safety of their relatives within the home. One relative said, "I feel the service keeps my relative safe and comfortable." Another said, "My relative is kept safe and the care is very good." A third said, "As my relative has dementia, it's good to know that the home is safe and secure."

We received mixed messages from people as to whether there were enough staff to meet people's individual needs. Some relatives felt there were enough staff with one saying, "Mainly I think there are enough carers on duty, but I can only say what I see when I'm there." Another said, "There does seem to be enough staff around to make sure my relative is safe and gets all the care that we agreed." However, some relatives raised concerns, particularly around the consistency of nursing staff. One relative told us, "The carers are very good, but they seem very short staffed all the time." Another said, "There does seem to be a bit of a turnover in nursing staff."

Prior to our visit, we had been made aware that a number of nursing staff had left the service with only one member of permanent nursing staff remaining in post. As this member of staff only worked two shifts a week, this meant that for three months most of the shifts had been covered by agency nurses. The provider had tried to ensure the same agency nurses were used, but this had still impacted on continuity and consistency of care. One member of staff told us, "You need the continuity so staff know people living here, but they were trying to block book the same nurses with the agency." Another confirmed, "The agency nurses have been coming quite regularly." However, some of the agency nurses had not had the skills to meet the individual needs of people living in the home. One relative told us that agency staff had not managed their family member's health condition appropriately. They had also tried to give the person medicine that was not prescribed for them and medicine that was not required. There had also been an occasion when a person had been admitted to hospital because the agency nurse on duty did not have the clinical skills to manage a medical event. A member of staff expressed concern that some people had been admitted to hospital unnecessarily when agency nurses had not known their usual health history.

The week before our visit the service had used agency nurses to cover 121 hours in the home. Two new nurses had been recruited, one had started work the week before our visit and the other on the day of our visit. The area manager told us it was predicted that agency usage would be reduced to 44 hours by the week following our visit.

Care staff told us that on the present numbers of people living in the home, there should be four care staff on duty during the day. Staff told us that everyone in the home required the support of two staff with all personal care needs. One explained, "There aren't enough staff, we run ourselves into the ground to care for people, the level of dependency here is high."

On the day of our visit there were only three care staff on duty as one had phoned to say they were unwell. We asked a member of staff how this impacted on the care provided. They responded, "If there are three of us on duty and one is at lunch and the other two care workers need to assist someone, there is no one there to help people." Another member of staff told us that the previous week there had been an occasion when there had only been two care staff on duty. A relative felt that the lack of care staff impacted on the standards of personal care in the home and said, "[Person] doesn't get washed until 12.30pm and dinner is at

Requires improvement

Is the service safe?

1.00pm." A member of staff confirmed, "Often it's hands and face and when we have more time we will wash people properly." Another told us, "We always make sure they are done before lunch."

One member of staff told us that due to pressure on their time they could not always get everybody out of bed during the day. They explained, "Sometimes we can't get people out of bed because there aren't enough of us. If we don't get them up one day, we will the next." They went on to say, "We can't work any harder, we are so busy feeding and turning people; we don't have time to give the care we want to." A relative told us, "I have real concerns because there don't seem to be many people up. I know some are really poorly but there are some who could get up."

During our visit we found staff were very busy and had little time to spend with people outside of providing personal care. Only three people were out of bed and we saw there were long periods when they were left in communal areas with no staff presence. One person was calling out for assistance, but there were no staff around. When we alerted staff, they responded promptly.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff said they would refer their concerns to the manager and if necessary to someone more senior. One member of staff said "I would report to my manager and or go to the CQC if I wasn't happy. I want to keep people safe." Another told us if they felt the manager had not taken appropriate action they would have to take it further. They said, "I would go to the regional manager and if they didn't do anything I would take it further. There is always yourselves."

Staff recruitment files contained a check list of documents that had been obtained before each person started work. We saw that the documents included records of any cautions or convictions, references and evidence of the person's identity. This gave assurances to the manager that only suitably qualified staff were recruited.

Identified risks to people's health and wellbeing had been assessed for individuals and management plans developed to minimise the risks and protect people from harm. We saw risk assessments relating to issues such as medical conditions, nutrition and hydration and protecting skin from breakdown. One relative told us, "The staff are very good at keeping my relative safe, especially with my relative's poor mobility by walking alongside and preventing any falls." However, during our visit we observed that all three people sitting in the lounge had been left sitting on the slings used to transfer them from bed into their chairs. This could cause discomfort and be a contributory cause to skin breakdown. The nurse on duty agreed people should not be left on their slings and made immediate arrangements for them to be removed.

Requires improvement

Is the service effective?

Our findings

People we spoke with were confident that permanent staff had the skills and knowledge to meet people's needs. However, some people raised concerns that agency staff did not always have the same skill sets. One relative told us, "When I have been there the staff seem competent in providing the care." Other comments included, "The staff seem to be well trained as they know what they are doing," and "I believe the staff are competent and trained sufficiently to offer all the care our relative needs." Some relatives raised concerns about the number of agency staff and queried whether they always had the right skills needed to meet the needs of their family members.

Prior to our visit we had received information that nursing staff did not have the clinical skills required to meet people's needs. This had resulted in people who had syringe drivers not receiving the most effective care for them. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin. There had also been concerns around the management of percutaneous endoscopic gastroscopy (PEG) within the home. A PEG is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach. The manager told us they had identified that some agency nurses were registered mental nurses (RMNs) and therefore did not necessarily have the skills to support the general nursing needs of people. They had therefore made the decision not to accept agency RMNs. All the newly recruited nurses were registered general nurses (RGNs) (apart from the new deputy manager) and would receive extra training to ensure they had the skills to meet the nursing needs of everyone in the home. The manager explained they had recently declined an admission to the home because they had identified they did not have the skill sets within the home to meet that person's needs. One newly recruited member of nursing staff confirmed they had syringe driver training arranged.

However, we identified that learning was not always being put into practice. For example, we heard an alarm to indicate a person's "feed" through a PEG had completed. The alarm went off for 20 minutes and staff only took action when we alerted them to it. Whilst no harm came to the person, there was a chance of complications which could have impacted on the person's health and wellbeing.

Care staff told us as part of their induction when they started working at the home they had shadowed and then worked alongside more senior and experienced staff. This meant they could observe them working and learn from them. One care staff member told us, "I had three days when I was following, making sure I knew everything that needed to be done. After the three days I was quite confident to work with somebody else."

Care staff told us they received training in all the areas considered essential to meet people's health and safety. Staff felt the training they received supported them to provide safe and effective care. We were told that training was planned to provide staff with further skills and knowledge, such as preventing damage to fragile skin and falls prevention.

Staff did not feel supported in their roles because they did not receive appropriate ongoing supervision to make sure their competence was maintained. Nursing staff had not always been supervised until they could demonstrate required or acceptable levels of competence to carry out their roles unsupervised. Records showed that nursing staff had not received any clinical supervision in 2015. Whilst care staff had been provided with group supervision on a couple of occasions, they had not been provided with the opportunity to discuss their own training and learning needs on a one to one basis. One member of staff told us, "We don't get one to one supervision, I can't remember the last time. We have group supervisions but you can't speak confidentially in those. I should know how I am doing and be reassured."

Staff had not been provided with annual appraisals where they could discuss their developmental needs and set personal objectives over the coming year.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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

Is the service effective?

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.

Mental capacity assessments were in place and reviewed regularly. Capacity assessments for individual decisions involved the person, their family and appropriate healthcare professionals. We found staff followed the principles of the Act when providing people with support and respected the right of people with capacity to make decisions about their care and treatment. Staff understood the need to support people to make their own choices. For example, one person had a bed rail and there was evidence around a best interest discussion to explain why it was in their best interest to have one.

Staff knew they should gain people's consent before they provided care and support. We saw one member of staff asking a person for permission before assisting them back to their bedroom. We asked one member of staff what they would do if a person refused support. They responded, "Definitely not force them. I would go back an hour or so later and see if they wanted it then."

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).The manager understood their responsibilities under the legislation. They had identified that some people could have some restrictions on their liberty and submitted the appropriate applications to the authorising authority the week before our visit. However, care staff we spoke with were not aware when people's liberty was being restricted. We asked one member of staff whether any applications had been made under the DoLS. They responded, "Not as far as I am aware."

People we spoke with told us they were happy with the standard of food provided. Comments included, "From what I know the meals that are provided are nutritional and there are several choices," and "The food is good and there are some choices."

Food was cooked fresh on site and menus were devised by the cook. People were not involved in menu planning, but could order whatever they wanted if they didn't like the menu. The cook explained, "If we have it, they can have it." On the day of our visit, we saw one person declined the meal they were given. They were offered an alternative which they ate. There was a list of people who required special diets and pureed meals in the kitchen and a likes and dislikes board. One relative told us, "When I have been there the food they provide is good as far as puree food goes, it's still in the individual portions." Where people were at risk of malnutrition their meals were fortified with cream, butter and milk and they were given fortified drinks. Snacks and drinks were provided through the day.

Some people had their food and fluid monitored to ensure they ate and drank enough to maintain their health. We saw charts were completed and checked regularly by the nurses and interim manager. This ensured staff were maintaining an accurate record so action could be taken if people were not eating and drinking sufficient amounts.

We spent a period of time observing in the dining room to see what the lunchtime experience for people was like. Only three people ate in the dining room, everyone else ate in their bedrooms. In the dining room the tables were laid and there was a warm and enjoyable atmosphere. The meals we saw looked appetising.

Care records showed people were referred to appropriate health and social care professionals. These included the person's GP, dietician and the speech and language team (SALT). Most people told us the service referred people promptly to external healthcare professionals where a need was identified. One relative told us, "Any medical treatment is arranged by the home staff," and another explained, "If there has been a medical appointment and I couldn't make it, staff would call me and let me know the outcome." However, some relatives were not happy that referrals were made as promptly as they could be. One said, "I had to prompt to get a referral to the dietician." Another relative told us family members had referred a health matter for one person to an external body because they did not feel the service had taken appropriate action when requested to.

Requires improvement

Is the service caring?

Our findings

All but three people were cared for in bed on the day of our inspection. Care staff ensured people's privacy was protected when providing personal care and closed bedroom doors. As care staff had little time to spend with people in their rooms outside of delivering personal care, we had limited opportunities to observe interactions between care staff and people. Three people spent time in the communal lounge, but again, there were long periods when there was no staff presence and very little interaction. Those interactions we did observe were warm and friendly and staff spoke with people in ways that were respectful.

We spent time talking with people and relatives about whether they thought staff were caring. The feedback we received was positive. People spoke highly of the caring attitude of staff and told us they found them kind and helpful. One relative told us, "They are caring staff and I have no concerns about my relative." Another relative told us, "It's really a brilliant home, it's loving and caring and I have no concerns about my relative's health or any other issues."

Some people raised concerns about consistency of nursing staff and the management of the home, but stressed their concerns were not around the caring nature of the staff. One relative told us, "The care staff are dedicated, they understand the people but nursing and management has been chaotic recently." They went on to say, "[Person] has the friendship and support of the carers here."

People told us permanent staff had a good understanding of people's needs and preferences. One relative told us, "The care team are well aware of my relation's care needs and are caring and compassionate."

Staff told us they enjoyed working at the home. They demonstrated an eagerness to provide caring, compassionate care, but told us they did not always have time to sit and spend quality time with people. A typical comment was, "I love this job, you don't come here just to do a job though, and it has to come from your heart. I am proud of what I do, I like to care for the relatives as well. I want the time to care." A new member of staff commented, "It seems a homely atmosphere, care staff are caring, it has great potential."

People confirmed that staff respected privacy and they had no concerns in this area. One relative told us, "If I'm there and they need to do something with my relative, they ask me to leave the room due to my relative's privacy."

We received very mixed opinions about whether people's dignity was always maintained. Some relatives had no concerns and told us their family member always looked clean and tidy and their dignity was maintained. One relative told us, "My relative is well presented so I have no worries there." Another said, "He is always clean and his clothes are always clean." However, some relatives felt their family member's dignity was not always promoted because their personal care needs were not consistently met. One relative told us, "They are quite caring but they don't seem to have time to wash and bath people. [Person] sometimes smells." Another said, "I have to ask them to give [person] a shower." One relative raised a concern that the hairdresser did not appear to visit the home anymore. This was confirmed by another relative who said, "I don't think anyone has their hair done."

Relatives and friends were able to visit when they wished and welcomed into the home. However, we found that a lack of information from the management of the home had made relatives anxious and in some cases affected contact with their family members. For example, there had been a recent infection in the home. Although action had been taken to reduce the risks of the infection spreading, relatives had not been kept informed. One relative told us, "There was no communication about scabies in the home and [person's] relatives no longer want to visit because of this. I arrived on the day they were carrying out the investigation. The carers told me, not the management; I never received a letter about it." Another relative told us they had not received any information or confirmation of the infection and heard about it on the "grapevine". They told us this had caused them anxiety and concern.

Staff did not always feel cared for by the provider. Staff we spoke with told us they felt vulnerable because they had not been fully informed about recent changes in the home. One member of staff told us, "I would like them to tell us a bit more rather than having to wonder what is going on. I would feel more cared for (by the provider) if they always made sure there were enough staff on." We asked what impact a lack of information had on staff. They responded,

Requires improvement

Is the service caring?

“That is why people (staff) feel insecure.” Another staff member told us they did not always feel valued and said, “We don’t get praised, it makes me feel like I want to work somewhere else, and we are flogging ourselves silly.”

Requires improvement

Is the service responsive?

Our findings

On the day of our visit, most people remained in bed all day. Three people sat in the lounge watching television with very little engagement from staff. The home had an activities co-ordinator who worked five days a week. They were not working on the day of our visit and as staff were busy delivering personal care, there were no activities offered to engage and stimulate people. We asked one person how they found the home and they responded, "Well not a lot happening is there? It's like this every day."

People we spoke with were generally happy with the level of engagement when the activities co-ordinator was in the home. One relative told us, "[Activities co-ordinator] is lovely and goes into see Mum in her room; she did a beautiful display for Halloween." Another relative described the activities co-ordinator as "brilliant" whilst another said, "There are things to do during the day to keep my relative occupied." A staff member said, "[Activities co-ordinator] is good at their job. On 11 November she did the lounge up with poppies and they had a Poppy Day. She goes round and reads to people." Another staff member explained, "Singers come in and they have armchair aerobics and do sensory stimulation. [Activities co-ordinator] will also go and sit with people in their rooms if they can't come down. There are activities 5 days a week."

However, some relatives raised concerns that people could become isolated if they spent large parts of the day in their bedrooms. One relative told us, "[Person] likes company. She likes lots of people. She likes to talk to people and there doesn't seem to be much going on here." We observed one person in their bedroom. The television was on but the volume was turned right down and the television was positioned so they were unable to see it easily. Another person's care records said they liked listening to soft classical music. We did not see this happening during our visit.

We looked at three people's care plans. Care plans and assessments contained detailed information that supported staff to meet people's needs. There were plans in place to support staff to meet people's specific health needs and included signs for deterioration in health. For example, one person had an area where their skin had broken down. There was an up to date care plan informing staff how it should be managed and staff were monitoring and dressing the sore in accordance with the plan. We checked one person who was completely reliant on staff responding to all their personal and healthcare needs. We saw their eyes and mouth looked clean and moist, their bed rails were checked regularly and they were repositioned in accordance with their care plan. Their weight chart was up to date and their weight was stable.

There was limited information in care plans about people's wishes for end of life care. For example, two care plans we looked at did not explain whether people wanted to spend their last days at the home or be admitted to hospital.

We found that care plans had not always been reviewed as regularly as required. The manager accepted this was due to the high use of agency nurses in the home and would be addressed now new nurses had been recruited.

People had been involved in formulating and reviewing their care plans. One relative told us, "We are involved in the reviewing of our relative's care plan and similar thinks like that." Another said, "The care is good and compliant with the care we agreed." A third relative said, "Mum has choices about what she wants to do and is involved in deciding what she wants to do and is involved in planning her care."

Life histories had been completed for some people, but staff were reliant on relatives providing the information. One relative told us, "They keep asking me for my relative's history and I haven't quite got around to providing that, my fault, not theirs. I must make an effort to get this information to them so they are aware of my relative's likes and dislikes." This information was important as it supports staff in providing individualised care and holding meaningful conversations with people.

Staff told us there were handover meetings between each shift when they would be informed of any changes in people's health so they could respond appropriately. One staff member told us, "In handover a lot of things are discussed. It is like a daily meeting. There is a huge lot of information in the handovers."

Information about how people could raise complaints was displayed on a noticeboard in the entrance hall of the home. One relative told us, "If I needed to raise issues, concerns or complain I would speak to the manager." They went on to say, "There are staff around and if I need to speak to them with concerns, they would listen to me."

Requires improvement

Is the service responsive?

We looked at the complaints that had been received. The complaints folder contained three complaints in 2015. These had all been handled and investigated in a timely manner and the complainant had been informed. However, some relatives told us they had raised concerns in recent months. Whilst these concerns had been raised verbally, we could not see any records had been maintained. The manager and area manager told us they were not able to confirm with any assurance that the records accurately reflected all the concerns and complaints received at the home. They told us they would ensure all formal and informal complaints received were properly recorded so they were able to identify any emerging trends and take appropriate action.

Inadequate

Is the service well-led?

Our findings

The home had not had consistent management for eight months. The previous registered manager had left and an interim manager had been appointed. The interim manager had subsequently gone on sick leave and another manager had provided oversight of the home. Four weeks before our visit, a peripatetic manager (a manager who provides support as required) had been put in place to support the home until a new registered manager was appointed. The home did not have a deputy manager as the previous one had left the service during the summer. A new deputy manager had been appointed, but there was uncertainty as to when they would commence working in the home. Due to staff absence in another home in the provider group, the administrator to the home was temporarily working on a part-time basis.

The peripatetic manager did not have a clinical background, and as the provider had been relying on agency staff to cover most of the shifts, there were significant periods when there was no clinical leadership within the home. In the interim, a registered manager from another of the provider's homes was providing clinical support as required. However, it was accepted that on average they only visited the home once a week and most of the support provided was over the telephone. During our conversations with the peripatetic manager it was clear they had limited knowledge about the needs of the people who lived in the home and the skill sets of the staff working there. The peripatetic manager was unable to access some of the computerised documentation because they were still awaiting access to the system.

Most people spoke positively about the standard of care within the home and the knowledge of permanent staff. However, they expressed concerns about the management of the service and some relatives told us standards had slipped over a period of time. Comments included: "I'm happy with the service my relative gets." "We are not happy with the care that is now provided; it has got a lot worse." It's an okay home and I have no worries or concerns about the quality of care provided for my relative."

On the day of our visit an area manager visited the home. They had only recently taken over this role as the area manager for the home had been on long term sick leave. The area manager was open and transparent about the constant changes in the management structure within the home and at area level and the detrimental impact this had on the service. They told us, "There hasn't been sufficient oversight. I can't change what has gone before, but I'm staying in the interim." One staff member said, "The regional manager went sick, now we have got [new area manager], but I don't know whether she is permanent or is taking over for a while. Nothing is being cascaded down." The area manager accepted that their appointment was only temporary and it was not clear yet whether it was going to be made permanent.

Staff voiced their concerns about the leadership within the home. Staff felt stretched and disheartened with the amount of changes to nurses and managers in the last few months. A staff member told us, "It's been worrying, the last six months in particular, so many nurses have left and we haven't had a manager or deputy manager. It's like a ship with no captain. They are trying to bring managers in, but you can't build a good team without managers. We lost about 4 or 5 nurses, then the deputy manager left and then it was like a pack of cards, things went down." Another member of staff said, "I think it is a bit down purely because there have been no permanent nurses and there is always a question mark when there isn't a registered manager."

Staff told us they were hopeful improvements were going to be made and spoke positively about the two new nurses who had been recruited. Staff also said that the peripatetic manager was having a positive impact. Comments included: "Since [peripatetic manager] arrived, it is picking up again," and, "We lost three nurses about the same time and it's been running on a lot of agency nurses. It's really positive we now have two new ones." One staff member explained, "That (the nursing situation) seems to be settling down now. Once the permanent staff are here and we know they are going to stay we will all be happier. I would be happier if there was a manager and assistant manager." We spoke to both new nurses who were very motivated to make a success of the home; however, both told us they would need support to make this happen.

Relatives we spoke with expressed similar concerns and told us that due to the number of managers there had been, they were not sure who the manager was at the time of our visit. When asked, one relative responded, "No, I don't. It keeps changing." Another said, "No, not at the

Inadequate

Is the service well-led?

moment. There have been three managers in the last two years. I don't know who it is at the moment." One relative told us, "We need a static manager here and nurses, we need continuity."

We received mixed responses from relatives when we asked whether communication was good and they felt informed. Some relatives told us communication was very good. One relative said, "In the time my relative has been in the home we have had good communication with staff and they let me know of any concerns they have, they would call me." Another said, "I have always got on with the staff and managers and there's good communication between us." However, some relatives told us communication was not always good. One said, "I email to get information and request a phone call from the home, but don't get a reply back." Some relatives spoke about a lack of communication following the outbreak of an infection in the home. When we were notified of the infection, we were told that all relatives would be informed in writing. Relatives told us this had not happened.

Some relatives and staff raised concerns about the future direction of the home. There had been no recent staff or relative's meetings where these concerns could be discussed, although some staff told us they would feel confident to raise issues. One told us, "If we had any concerns we would definitely raise it, and I know [peripatetic manager] is always there." Another said, "I do think there is an open culture here, but they don't see what we do every day." The area manager told us they would organise some meetings as a matter of urgency so they could explain the plans for the home and reassure people about the provider's commitment to the service.

The provider had a system of audits and checks in place to monitor the quality of services provided in the home. The manager and provider were both responsible for carrying out these checks. The manager and area manager accepted that some of these checks had not always been carried out as required. The manager was responsible for carrying out spot checks and "walkabouts" in the home to look at quality of care, safety and cleanliness. The area manager had identified that these checks were not being completed at weekends which could lead to inconsistency in the delivery of care.

We asked about incidents and accidents in the home and what actions the provider took to reduce the likelihood of them happening again. The area manager told us information was recorded onto a tablet computer and that this could be done by any member of staff. The manager would then analyse the information and put action plans in place to make improvements such as updating people's risk assessments or referring them to healthcare professionals for support. The area manager told us they also analysed this information to ensure problems were being dealt with correctly by the manager. However, we saw that an audit by the area manager on 5 November 2015 had identified that not all incidents were being recorded. This meant we could not be assured all emerging risks would be appropriately identified so action could be taken.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The CQC ratings from our last inspection were displayed and a copy of the report was available. This meant that people, relatives and visitors could see what we said about the provider and improvements they needed to make.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not always sufficient numbers of suitably competent and skilled staff to meet the individual needs of the people who used the service. Regulation 18 (1) Staff did not always receive the appropriate support to enable them to carry out their duties competently. Regulation 18(2)(a)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to monitor the quality and safety of the service provided, including the quality of the experience of service users in receiving that service. Regulation 17(2)(a)**

The enforcement action we took:
We are currently taking enforcement action. We will report on this once it is concluded.