Barchester Healthcare Homes Limited

Latimer Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 7 October 2016 and was unannounced.

The home provides accommodation for a maximum of 80 people requiring nursing and personal care. There were 51 people living at the home when we visited. People living within the home lived within one of four units. The units were named the Beaufort, Grosvenor, Woodbury and Avalon Units. People with higher or nursing needs were living within the Avalon and Grosvenor Units. The Beaufort and Woodbury Units were regarded as residential units.

A registered manager was not in post when we inspected the service as they had recently left. 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 and associated Regulations about how the service is run. The registered provider was seeking to recruit a replacement manager. A general manager employed by the registered provider was managing the home in the interim. A further general manager was due to join the home shortly with the aim of applying to become the registered manager.

People living at the home were supported by a number of different agency staff that they were not always familiar with and who they were not certain understood their support needs. The registered manager told us they had recently begun to employ the same nurses in order to assure themselves of nurse's competency skills. The registered provider had lost a number of key staff, including the registered manager within the recent months and this had exacerbated people's concerns.

People and their families sought continuity of care through regular staff and a permanent registered manager. The registered provider did not ensure people had access to regular staff and there was a dependency on a number of different agency staff. Since this Inspection, the registered provider told us they had put in measures to retain the same agency staff whilst also actively recruiting permanent staff in an attempt to aid consistency.

The registered provider had established a system for people and families to contribute to care planning but this was not in operation. People and their families did not have faith in the system because people were not able to share their ideas about care planning. People did not have a named member of staff they could direct their queries to.

People did access a GP or other professionals when they required. People were also supported to make choices about the meals and the food they ate. People requiring support with their meals were offered this.

People did not always participate in activities they would like to pursue because the home had lost the services of an Activities Co-ordinator. We saw that a new Activities Co-ordinator had been recruited and had commenced work.

People and their families understood how to complain but had grown frustrated at the process. A number of key staff had left the service, including the registered manager, and relatives had instead contacted the Care Quality Commission to seek redress. People and their families did not feel there was a commitment to leadership within the home or to keeping in communication with them. A meeting with family members had been cancelled and this had added to a sense of frustration.

People living at the home had seen a number of different managers join the home and then leave after a short period of time which had caused uncertainty and anxiety. Staff sought strong leadership, support and direction but were not able to access this.

A number of systems within the home required the input from either the manager or clinical lead to ensure their effectiveness could be maintained. When the registered manager left, systems were not maintained which affected people's care and their confidence in the running of the home.

Systems in place to assess and monitor the quality of the service provided were not effective. We found multiple breaches of the regulations. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always sure if there would be enough staff to support them. People felt safe around staff that were there and did not feel concerned for their personal safety.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for by staff that did not have access to regular supervision and training. People's ability to consent to treatment was reviewed and recorded for staff to refer to, although this was not always in a systematic manner. People received support to maintain a healthy diet.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by a number of different staff with whom it was difficult to build an on-going relationship. People were not always involved in making decisions about their care. People's dignity was promoted.

Is the service responsive?

Inadequate

The service was not responsive.

Some people were supported to pursue individual interests but not all people. People did not feel that they were able to share their view of the service and that these would be listened and responded to.

Is the service well-led?

Inadequate

The service was not well led.

The service had struggled to retain a manager and people and staff had become frustrated with the changes. People's care was not always reviewed in a systematic manner. The registered provider's checks of the how people received care were not always robust.

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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 previously carried out an inspection on 23 and 24 November 2015 and found that the service was Inadequate in two areas, Safe and Well led as well as being Inadequate overall. We then placed the service in Special Measures to give the service time to improve. The registered provider sent in an action plan of how they were going to make improvements. We re-inspected the service again on 10 and 12 May 2016 and found that enough improvement had been made to lift the service out of Special Measures, although there were still some areas of improvement needed.

This inspection took place on 7 October 2016 and was unannounced. The inspection was carried out by three inspectors.

The inspection was brought forward in response to concerns raised with CQC from staff, relatives and members of the public. The concerns focused on inadequate staffing levels and the lack of management within the home. We also spoke with the Local Authority and requested information about the service from the Clinical Commissioning Group (CCG). They have responsibility for funding people who used the service and monitoring its quality. We also reviewed information we held about the service and looked at the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

As part of the inspection we spoke with nine people, seven care staff, two nurses, the manager, the clinical development nurse and the regional director.

We observed care and 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 reviewed three care records, the complaints folder, recruitments processes as well as monthly checks the manager completed. We also reviewed eight applications submitted to deprive someone of their Liberty.

Requires Improvement

Is the service safe?

Our findings

The home was inspected on 23 and 24 November 2015. At that inspection we found concerns with staffing levels at the home and rated this section as Inadequate. We issued a Warning Notice and gave the provider time to address our concerns. The home was also placed into Special Measures for six months. We re-inspected the home in 10 and 12 May 2016 and found there were improvements. There were however some areas for further improvement around how people's concerns about their safety were recorded and shared with the management team.

At this inspection we found people living at the home were again concerned about the high turnover of staff. One person told us, "We have different staff all the time." Relatives of people living in the home did not always feel their family members were safe at the home. Relatives told us they were concerned that there were not enough staff to adequately support people. One relative told us their family member was, "Vulnerable and the agency staff don't know him." The relative was scared the agency staff would not understand all of the person's behaviours in order to keep them safe. The relative told us, "The agency staff are not regular". They told us they had experienced months of feeling that staffing levels were not appropriate. The manager and regional manager accepted that people had experienced care from a number of different nurses and staff and had recently introduced measures for staff to work more regular patterns within units.

At the time of the inspection visit, the manager told us that they did not have enough numbers of permanent staff and they were reliant on agency staff. There was one permanent nurse working at the home with knowledge of people's needs, who worked on a part time basis for 18 hours a week. The manager told us three nurses usually worked at the home during a shift which meant the majority of nursing cover was through agency nursing. We looked at staffing rotas during September 2016 which confirmed the reliance on agency nurses to provide the majority of care. Staff we spoke with told us that there were sometimes different agency nurses and there was not always continuity in care because the same nurses did not always attend the home. One staff member we spoke with told us they were aware of issues within the Nursing Units because of the reliance on agency staff. We saw that a fluid chart initiated by one nurse was not followed on when the next nurse came on duty, so we could not be assured that the person had received the correct amount of fluid for that day.

The manager told us the home used a system to assess each person's dependency, which determined the necessary staffing levels at the home. The manager advised us they were in the process of updating each person's assessment so it reflected an accurate record of people's needs. The manager told us they planned to complete this within the coming weeks. The manager told us they were not able to accurately know the staffing levels needed to safely manage people's care needs until this had been completed. The registered provider could not be assured that information was up to date and that they enough staff on duty to meet people's needs. Staff told us agency staff were used to cover shifts when there were not enough other staff working. Staff described a system of allocating staff that was not clear to them. One staff member told us that the weekend prior to our inspection, too many agency staff had been booked and this had created confusion and had resulted in one person receiving their lunch twice. The management team told us they

were working to improve the staffing arrangements so the number of agency staff was reduced. They acknowledged that the use of agency staff did not allow consistency of care for people although they were in the process of ensuring the same agency staff were used regularly to help to reduce the impact on people. The provider told us during the inspection that they were recruiting staff and that some were due to start imminently.

The manager told us they were working to ensure staff understood the risks to each person's health. To address the concerns about agency staff, one permanent member of care staff was working in each team alongside the agency staff to provide direction. During our observations with staff on the day, we saw this had been implemented. We saw that where care staff were unsure about a person's needs, they spoke and checked with the permanent staff member to gain clarification. We also reviewed the handover sheets nurses used to update care staff and saw that this included risks to people's health that care staff needed to be aware of. We saw that the information contained any conditions that people lived with together with what people's nutritional needs were.

People told us they felt safe and did not feel concerned about their personal safety. People told us they liked the staff that they were familiar with and did not have any concerns about how staff treated them. Staff we spoke with told us they had received Safeguarding training and they understood what to do if they were concerned about a person's safety and wellbeing. They understood how to document the information so that a record of their concerns existed. They understood that they could share their concerns with a senior member of staff or contact the local authority directly if they needed to. Staff we spoke with could explain how abuse could be defined and spoke confidently about recognising the signs. We reviewed notifications sent to us by the manager and saw that they had sought advice from the local authority when they required clarification. The manager understood their obligations in relation to safeguarding people and understood how information needed to be recorded and where relevant information needed to be shared with the local authority and Care Quality Commission.

Arrangements were in place to make sure medicines were available for people when they needed them. One person told us, "The staff always make sure I regularly have my tablets." Medicine records we looked at showed people had received their medicines. We saw an agency nurse assisted people to take their medicines, such as making sure people had drinks so they were able to swallow their medicines safely. The agency nurse told us they had appropriate training to support people in taking their medicines which helped to reduce risks to people's health and wellbeing. We saw safety precautions were in place so medicine errors could be identified and action taken to reduce risks to people. We saw staff wore a tabard while they administered medicines as a reminder that they must not be disturbed. Although we did see the nurse interrupted the medicines round to make phone calls.

Requires Improvement

Is the service effective?

Our findings

The home was inspected on 23 and 24 November 2015. At that inspection we found concerns around how staff were supported and with the system for obtaining a legal authorisation to deprive someone of their liberty. We again re-inspected the home on 10 and 12 May 2016 and found there were improvements and rated this question as Good.

At this inspection, people's experience of staff was inconsistent across the home. We spoke with people to understand whether they felt assured that staff had the training and knowledge to care for their family members. Some people we spoke with described their experience with staff as positive. However, two relatives we spoke with expressed concern. One relative told us, "We don't trust the staff - that they know what they're doing." Relatives we spoke with told us they had become concerned because of the volume of agency staff needed and the lack of management within the home. They were concerned that staff were not being supervised or offered direction.

One person told us they did not know whether agency staff had the same training and understanding as permanent staff working in the home. This had left some people and their families feeling anxious because of the high number of agency staff within the home. We saw one example during the inspection when an agency nurse intervened to prevent a thickener being used and instead suggested bread crumbs were used to thicken a soup. A relative told us their family member had accessed medication that had been left out in error by another agency nurse. Although no harm come to the person, they were concerned about the training and supervision offered to staff working at the home.

Staff told us they were not able to access regular supervision and did not always feel supported. Staff told us since the last inspection on 10 and 12 May 2016, access to supervision had decreased and staff meetings had also ceased. A number of the management team had left and had not yet been replaced and other staff were not able to carry out the supervisions. One staff member told us there were, "No supervisions." When we checked with the manager, the manager and senior staff confirmed that supervision meetings had ceased. One staff member told us about senior staff, "I don't know if I'm supported in the home." Another staff member discussed not feeling supported in their job.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 also looked at the Deprivation of Liberty Safeguards (DoLs) which aims to make sure people are looked after in a way that does not unlawfully restrict their freedom. The manager told us that where appropriate, all people that required an application for a DoLs, had been assessed and applications submitted the previous day. The manager advised us that copies of the paperwork were in the process of being added to people's care plans. When we reviewed the applications we saw that applications had been submitted and that staff were adding these to people's care plans. We also saw that in daily handover sheets, notes had been added that reflected whether or not an application for a DoL had been applied for, for each person. However, we did see that on least two occasions, people's DoL authorisations had lapsed before a further application had been submitted. This meant there was a possibility that people may have had their freedom unlawfully restricted. It also demonstrated that the system for ensuring all applications were renewed in time was not effective.

Staff we spoke with could explain to us decisions that were made in a person's best interests. For example, one staff member explained it could be to do with a supporting a person to get changed, when needed if they were not able to make that decision on their own.

People were able to access support from services such as the GP, optician and dentist. One person told us they had recently been visited by the chiropodist. Another person told us they saw the doctor when they needed. People we spoke with told us that the GP visited regularly and that nurses could contact the GP if needed. We saw during the inspection that one person became poorly and required the input from a GP and the GP was called out to visit the home.

We saw during the inspection people were supported to have their meals. One person told us, "I eat most things. It's [meal] served on time." One relative told us, "The food is okay. He (family member) has a good breakfast and lunch." During the inspection we saw staff sat with people and offered support to complete their meal. The manager told us they were encouraging staff to sit with people during meal times to improve people's experience at mealtimes. We saw that people were offered choices in their selection of meals and drinks. One person told us that when they did not like anything on the menu, they were offered an alternative. We saw that people that required a specialised diet, such as a soft diet received these.

Requires Improvement

Is the service caring?

Our findings

The home was inspected on 23 and 24 November 2015. At that inspection we found concerns around how people were supported to maintain their Dignity. We issued the Provider with a Requirement Notice and rated this section as Inadequate. We re- inspected the home on 10 and 12 May 2016 and found that there were improvements. The rating was changed to Good at that inspection. However, we identified further concerns at this inspection.

We asked how people were involved in planning their care and how people's care was planned across the home. At our last inspection in 10 and 12 May 2016 we were told the registered provider had a system where each person had an allocated staff member who reviewed their care plan and liaised with their relatives where necessary but this had now ceased. Relatives we spoke with told us they did not always know who to discuss any concerns with and contribute to updating people's care plans. Furthermore, relatives we spoke with, talked of the lack of continuity of care because they did not always see familiar faces caring for their family member. Relatives we spoke with told us some of their family members lived with dementia and it was important for them to develop on ongoing relationship with staff who understood their individual needs.

People we spoke with understood that there were a number of both agency and permanent staff supporting them. They talked positively about a core group of permanent staff they had got to know over some time. People and their relatives we spoke with talked positively about the staff supporting them. One person described staff as, "Lovely." One relative described the staff as, "Very good…compassionate." People we spoke with liked and valued the staff supporting them and valued the staff with whom they had developed an understanding of their care over time. We saw examples of positive interaction between people and staff. We saw staff acknowledging people as they walked past as well as offer reassurance if people needed this.

People who lived at the home told us their families visited them whenever they chose to and they were able to visit at any time. We saw during the inspection people sat with their families in areas of the home they chose to be within. For example, one relative told us they sat with the family member outside sometimes in the garden when the weather was good. Another relative chose to sit with their family member in the person's bedroom. Some people chose to stay in touch with their family by telephone. One person told us they regularly telephoned their friends and family and also had a mobile phone.

We saw people were treated with dignity. People had been supported where possible to dress in a manner of their choosing. People were addressed by a title of their choosing, for example, some people were called by a shortened version of their name. When we checked with family members whether this was appropriate, they confirmed it was correct.

Staff we spoke with understood what caring for someone with dignity meant. One staff member we spoke with who supported people living with dementia explained to us the impact the dementia had on people's memories and their family members. They explained how they supported people to live in the moment they were experiencing. Where people required a shave they told us they supported people to have a shave.

Other people we spoke with told us they saw the hairdresser and had their hair done because it was important for them to maintain their appearance.

Inadequate

Is the service responsive?

Our findings

The home was inspected on 23 and 24 November 2015. At that inspection we found concerns around how people were supported to so that they received care individual to their needs. We issued the Provider with a Requirement Notice. We also found concerns with how the Provider was responding to complaints they received. We also issued a Requirement Notice to the Provider for failing to effectively respond to complaints. When we inspected on 10 and 12 May 2016, we noted improvements and rated this question as Good.

At this inspection, people did not always have the opportunity to participate in activities they would have liked to pursue. People living within the Beaufort Unit explained to us that some of the activities they enjoyed had recently reduced in frequency. They told us they enjoyed going out in the mini bus for a pub lunch but they had not done this for a while. Another person told us they hoped the activities might resume soon as "You get bored, especially in the evening." A relative of a person living in the Avalon Unit told us, "There's no activities. No stimulation so [family member] just falls asleep in the chair."

We saw an activity planner on the wall within the reception area and saw that it was bare. When we asked staff about what activities took place, one staff member told us they, "Weren't sure." In other parts of the home people looked uninterested and bored. We saw people sitting in the lounge with little stimulation. When we raised this with the manager, they told us they had lost an activity co-ordinator but a new one had been recruited and had started the previous day. They told us their priority was to work with staff to get activities happening. When we spoke with people they told they had met with the new activity co-ordinator. We saw that the activity co-ordinator had begun to initiate activities with people. We saw a group singing session take place for one group of people and people responded positively to it.

Relatives we spoke with told us when their family member first moved to the home, they spent time with staff explaining all the aspects of their care they thought staff needed to know about. It was important for relatives to have an opportunity to share the information they had about their family members preferences as some people living with Dementia were not always able to express themselves.

Two relatives we spoke with told us they and their family members were not always involved in making decisions about their care. One relatives told us, "The only way they involve me is if (family member) has fallen ill." This had caused the family members to feel anxious and concerned. The relatives told us they had spoken with staff about their family member's personal care needs. They told us each time they visited they checked that their family member's needs had been attended to because they did not have confidence that this would be done. Relatives did not feel the high number of agency staff understood their family members sufficiently because they were not involved in care planning and would not always know how to respond to their needs. One relative told us their family member might upset other people living at the home. They told us the permanent staff were familiar and knew when to intervene to distract the person. Another relative told us, "The girls that know mum are brilliant. That's what worries me about agency staff. Would they know?" One relative we spoke with told us they visited regularly to ensure their family member received support with their meals because they were not sure that agency staff would know how to support

their family member. The manager and regional director we spoke with told us people's up to date care needs were not known because the system for involving people in making decisions about their care has dissipated.The provider did not ensure people received care and treatment that reflected their preferences.

Where people received nursing care, people's records were not up to date for staff to rely on. On the day of the inspection, we saw that a nurse was undertaking a Wound Audit to ascertain people's care needs in relation to the condition of their skin. When we asked for evidence of clinical audits, one of the management team told us, "The systems are not in place." A number of additional audits were taking place in the home during our inspection to update the manager about people's current care needs. Systems to maintain this information so that people's care needs could be adjusted had lapsed.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

We saw the registered provider had a system for complaints and these were recorded and responded to. However, relatives we spoke with told us they were familiar with the complaints process but had lost faith in how their complaints were resolved. One relative told us since their relative had moved to the home; they had spoken with a number of managers and senior managers the provider had sent to the home. They did not feel their complaints about the home were being listened to and that they made a difference. One of the issues they had raised was about staffing and the lack of visible leadership within the home. Prior to this inspection, two relatives contacted us after they told us they had tried and failed to get the management of the home to listen to their concerns. When we looked at complaints that had been documented we saw inadequate staffing had been raised as a complaint in August 2016.

At this inspection when we spoke with people, families and staff, they all stated staffing was still an issue of concern. When we spoke with the manager and regional director they acknowledged people had complained and that there were issues families were unhappy with. Whilst they advised that they could not answer on behalf of the previous manager, they hoped to improve how they communicated with people and understand their concerns better. They also acknowledged that whilst people had complained, the changes in management had meant concerns were having to be raised afresh whenever a new manager started at the home.

The registered provider did not operate an effective system for handing and responding to complaints. This was a breach of Regulation 16(2) HSCA 2008 (Regulated Activities) Regulations 2014.

We asked about other ways in which the provider had sought to ascertain what people thought about the service. We were told by the manager that questionnaires had just gone out to people and staff were yet to receive these. Relatives we spoke with felt there were not enough efforts to understand their concerns. A relatives meeting had also been cancelled during the last few months. Two relatives we spoke told us they had been disappointed with the cancellation because they had wanted to speak to senior person from the service and express their frustration. When we raised this with the manager and the Regional Director, they told us a further meeting had already been arranged to speak with families and hear their concerns as well as talk through changes at the home.

We saw how staff communicated with people to understand their immediate needs. Staff responded to people's individual communication style. When people were able to indicate they needed support to attend the bathroom, they were helped. We also saw when people were ready to leave one room and asked for help to transfer to another room, they received this support. People that had required specialist equipment had access to the equipment. We saw that some people use wheel chairs or stand aid or equipment that was

appropriate to them.

Inadequate

Is the service well-led?

Our findings

The home was inspected on 23 and 24 November 2015. At that inspection we found significant concerns with how the home was being managed. We rated this section as Inadequate and issued the Provider with a Warning Notice. The home was also placed into Special Measures, until we re-inspected the home on 10 and 12 May 2016. At that inspection, although we noted improvements, we were still concerned with the governance of the home and the high turnover in management staff. We rated this section as Requires Improvement.

Since our last inspection on 10 and 12 May 2016 the provider installed a number of managers who had each led the service for short amount of time. A number of relatives had contacted the CQC prior to this inspection and expressed their frustration with the lack of visible leadership as well as inconsistent leadership within the home. The registered manager had recently left the service within a period of approximately six months and an interim manager was in post in to oversee the service by the provider. The interim manager was soon to be replaced by another temporary manager and would have been the sixth manager to run the home within 12 months. Staff described their working environment as unsettling. One staff member told us they had to "Try and get used to each manager's style." When we spoke with the Regional Director to understand why there had been so many managers, they told us that two permanent managers had left. The other interim managers had been placed at the home by the registered provider as a temporary measure to oversee the home.

Although relatives we spoke with understood there had been changes in management, relatives were also upset at the turnover in staff and the inconsistency of care people were receiving. Since the last inspection, the clinical lead had left, the deputy and registered manager had left, catering staff and a number of nurses and care staff had also left. Although they were replaced by agency staff where possible, this had created uncertainty and confusion for both people and their families.

At this inspection people who lived at the home and relatives we spoke with expressed frustration and anxiety at having no stable leadership within the home. One relative told us, "There's no leadership…staff need leadership". The relative went on to tell us, "The place is in crisis." Relatives told us they did not feel able to escalate their concerns about their family member's care because they did not always know who was in charge given the frequent changes in management. Staff also shared their concerns with how the home was being run. One staff member told us, "It's not consistent; the turnover (of staff) is huge." Staff we spoke with understood the Whistleblowing process. Prior to the inspection, we were contacted by two staff who shared their concerns about staffing levels at the home.

During our last inspection, we found that communication with people who lived at the home and their families was not always consistent. Relatives did not always feel they had an accurate picture of developments within the home and this had resulted in frustration which led some relatives to share their concerns with the Care Quality Commission. At this inspection relatives told us they had been made promises to keep them updated but had not happened. Furthermore, relatives told us they had met with a variety of managers and changes did not seem to happen. One relative told us, "They keep asking us to give

them time, but we don't have time." One relative told us, "I don't think the management care. They just care about the money."

The provider had systems in place to assess the quality of service provided and to record information about people's care. However, we found these were not effective because they were not always completed on a regular basis. We saw that the "Resident of the day" system was not effective because it had not been completed with regularity. At the last inspection, the registered provider told us they operated a "Resident of the day". They told us this helped them understand and fully evaluate each person's care and ensure they received the care they needed. The system also helped management staff determine how many staff were needed and how they should be deployed as well as how people should be supported. At this inspection we saw that four family members were concerned people's care was not understood by staff and that people did not always get the care they needed. Two relatives told us the only way to assure themselves that people received the care they needed was by visiting every day. One relative also told us they always checked to ensure their family's member's clothes were not soiled because they could not be certain staff understood their family member's needs. The Regional Director told they were in the process of updating people's needs because they recognised this had not been completed for some time and that some people's needs were not recorded fully.

During this inspection we found a number of areas of concern that did not assure us checks were robust. The quality assurance procedures needed to be strengthened to make sure some aspects of medicine storage and disposal were of a good standard and effectively promoted best practices. For example, the medicine disposal bin was full and there were medicines left on the top of the cabinets in the clinical room which needed to be disposed of. The staff member acknowledged this and informed us they would have to look around the home to see if there was a spare container for the purpose of the disposal of medicines. However, the provider's quality checks should have identified the need for another medicine disposal container to promote best practices. Additionally, we found the checks carried out on the storage of syringes were ineffective. This was because it had not identified syringes where the use by dates had expired to make sure these were removed from stock to avoid any being used. At our last inspection, we were advised by the provider that people's care would also be reviewed by the clinical development nurse who would audit people's care as well as clinical practices within the home. This system would be used to assure the provider of the standards they expected. Whilst we saw that on the day of the inspection people received support to have their medicines, other systems associated with the storage of medicines were not robust.

At the last inspection, the manager told us the Quality First audits were regular and were aimed at highlighting a home's areas for improvement. When we asked for evidence of the last Quality First audit, the last copy could not be found. The provider had not consistently monitored and taken action to improve the quality of service staff provided at the home. We saw audits were not consistently completed and issues acted on. An example of an ineffective system included the review of the system for ensuring that people's authorization for their Deprivation of Liberty had not expired.

The provider had a system for recording and monitoring accident and incidents. Staff completed forms and referred these to the manager. The manager accepted that prior to her arrival there had been a backlog of forms which had not been actioned. One staff member told us there were, "A lot of forms hanging around on units." The manager assured us that since the last inspection the forms had all been reviewed and updated onto the provider's online system and analysed to identify any trends.

The management team told us they recognised they still had work to do in making these improvements throughout the home. Additionally, the provider was aware the quality of the service people were provided required improving and sustaining as this had not been achieved following our last inspection visit. We

spoke with the Regional Director to understand how systems within the home aimed at monitoring care had not been effective. The Regional Director advised us the provider recognised the home was in need of "Focus" and an experienced team were being brought in to oversee care. She further advised that a restructure in the organisation that week should address some of those areas of concern.

The registered provider did not make regular checks of the service and had not ensured high quality care had been delivered. This was a breach of Regulation 17(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014.