Sherwood Grange Ltd

Sherwood Grange Care Centre

Inspection report

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20 September 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 13, 14 and 20 September 2017 this was an unannounced inspection. Sherwood Grange is a service providing residential and nursing care for older people with a variety of health conditions including dementia. The service is registered to provide care for 45 people and on the day of our inspection that were 33 people using the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst staff at the service showed a good understanding of their roles in relation to reporting any safeguarding issues, we found there were safeguarding incidents where the correct action had not been taken to protect people. This related to recommendations made by health professionals who investigated the safeguarding issues.

People's risks were not always fully assessed, up to date and information in them did not reflect their needs. The recommended staff levels were not always met and as a result staff sometimes struggled to meet people's needs. The staff recruitment processes in place were not always safe and robust. Medicines were not always managed safely and we found a number of errors relating to the administration of these.

Staff received training when they first started at the service but there was a lack of adequate mandatory training updates in place. Some staff who were providing practical training had not received the necessary training updates to show they were competent to deliver this training.

The principles of the mental capacity act were not always followed where people lacked the capacity to make their own decisions. Decisions had not always been made in people's best interests involving professionals and the person closest to them. There was a lack of information around advocacy for people in the service.

People's nutritional needs were not always met and although the health professionals we spoke with told us they had good relationships with staff we found some recommendations were not always followed.

Staff at the service treated people with kindness and respect and managed their privacy and dignity well. There was a lack of evidence to show people had been involved in developing their care plans although people and relatives told us they had some involvement in developing these. The care plans did not always contain sufficient detail of people's individual needs and staff felt information around changes in people's care was not always communicated to them in a timely way.

The activities for people at the service had been limited for a period of time prior to our visit and there was a

lack of engagement with people who spent a lot of time in their rooms.

The complaints procedure was not displayed in the service. The company's complaints procedure had not always been followed when people raised concerns and complained to the registered manager.

The service lacked robust systems and processes to effectively monitor the quality of the service. This included effective supervision of staff, auditing processes related to medicines, care plans, infection control, health and safety and the environment. There was a lack of engagement from the provider which resulted in a lack of support for, and oversight of the registered manager.

As a result of the above findings the provider was in breach of multiple regulations of the Health and Social Care Act 2008 (regulated Activities) regulations 2014.You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Safeguarding issues raised were not always responded to, to protect people from further harm.

Risk assessment were not always up to date and did not always reflect the needs of people in the service

Staffing levels did not always meet the required levels to enable staff to support people's needs. Staff were not always recruited safely.

Medicines were not always managed safely

Is the service effective?

Requires Improvement

The service was not always effective

There was a lack of ongoing mandatory training for staff and some staff who provided practical training, did not have up to date training for this role

The principles of the mental capacity act were not always followed as best interest meetings had not always been held for people who lacked mental capacity.

People's nutritional needs were not always met

Some advice form health professionals was not always followed so people's health needs were not always met

Is the service caring?

Requires Improvement

The service was not always caring

People were treated with kindness by the staff who provided care for them and their privacy and dignity was well managed

People told they had little involvement with their care plans and there was no evidence in the plan to show their involvement.

There was a lack of information for people on the available Advocacy services available and a number of people in the service would have benefitted from this service

Is the service responsive?

Requires Improvement

The service was not always responsive

The care plans did not always contain sufficient detail of people's individual needs and staff felt information around changes in people's care was not always communicated to them in a timely way.

There was a lack of social activities and there was a risk that people who spent time in their rooms may feel isolated.

Complaints and concerns were not always recorded and responded to in line with the provider's complaints procedure.

Is the service well-led?

Inadequate

The service was not well led

The registered manager was a visible presence at the service. However, staff and people told us they did not know the provider.

The service lack robust systems and processes to effectively monitor the quality of the service. This included auditing processes related to medicines, care plans, infection control, health and safety and the environment.

There was a lack effective supervision of staff and of opportunities for staff to feedback about the service

There was a lack of engagement from the provider which resulted in a lack of support for and oversight of the registered manager.

Sherwood Grange Care Centre

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 checked 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 13, 14 and 20 September 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor with a nursing background 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.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people who use the service) and asked them for their views. We used this information to plan our inspection.

During our inspection we spoke with six people who were using the service, two relatives and two visiting health professionals. We also spoke with five members of care staff, the activities co-ordinator, the registered nurse, a kitchen assistant, a member of the housekeeping team and the registered manager. We looked at the care plans of five people and associated daily records such as the daily log and medicine administration records. We viewed six staff files and also looked at a range of records relating to the running of the service such as training records and quality audits.

Inadequate

Is the service safe?

Our findings

Staff we spoke with had knowledge of the different types of abuse people may be exposed to when living in a care home. They were clear about what signs to watch out for to show if a person was being abused and they understood their responsibilities in relation to reporting any issues of concern. One staff member told us they would monitor any changes of behaviour in people and listen to anything a person had to tell them They said, "I would tell the nurse or manager (if they had concerns) and I can go to the CQC."

Despite the above, we found that effective action had not always been taken to implement recommendations resulting from safeguarding investigations. We saw there had been some safeguarding investigations undertaken by the local safeguarding team. Our records showed a safeguarding issue had not been reported to us at CQC. During one of the investigations a social worker had highlighted a new concern related to the person's weight loss and the fact there had been no monitoring of the person's fluid and food intake during this period. Whilst this information from the social worker had been recorded in the person's care plan there had been no actions taken to address their concerns and recommendations. There had been no further monitoring of the person's weight to identify if they had lost further weight since June 2017.This meant we could not be sure that the registered manager was taking appropriate action to safeguard people in their care. In addition, records showed and staff told us, that 25 staff had not received updated training on safeguarding. This meant we could not be assured that all staff had the skills and competence to act appropriately when safeguarding concerns arose.
We discussed this with the registered manager and asked them to address the issue. They told us they would address the issue. Following our inspection we also raised the issue with the local safeguarding team for further investigation.

Risks to people's safety were not always assessed and managed safely. Whilst people we spoke with told us they had equipment in place to assist them with mobility such as walking aids we found the risk assessments in people's care plans lacked detail about people's needs and were not always updated. For example, one person who had fallen recently and sustained an injury, had not had their risk assessment updated to show the current measures required to help prevent further injury. The person had fluctuating mental capacity and required assistance to mobilise and they sometimes tried to walk unaided. We observed the person had a sensor mat in place when they were in bed, but when they were sat in the lounge area there was no method of alerting staff when the person attempted to stand unaided. The use of the sensor mat was not recorded in the person's care plan and there was no information for staff about how to manage the risks to the person when they were seated in the lounge area. This placed the person at risk of sustaining further injury as the result of a fall. We discussed this with the registered manager who put a sensor mat in front of the person when they were seated in the lounge. However, the person then began to touch the mat with their foot setting off the alarm at times when they were not trying to get out of their chair. This did not assure us that proper consideration had been given to ensuring risks were appropriately managed. The registered manager told they had now ordered a different alarm that would more effective for this person.

During our visit we also saw another person had had increased falls over the preceding weeks. However,

when the person sat in the lounge, there were no measures in place to protect the person from further falls. During our inspection we observed the person attempt to stand unaided and no staff were present at this time. Another person living at the home called for the person to sit down which alerted ourselves and the registered manager. The registered manager prevented the person from falling and assisted them to sit down in their chair. The registered manager told us they had referred the person to the falls team and was awaiting assessment. However, there were no interim measures in place to reduce the risks to the person when they were sat in the lounge area. Following the incident the registered manager put a sensor mat in front of the person's chair so staff would be alerted should they try to stand unaided.

The risk assessments we viewed contained conflicting information about people's needs. For example we viewed two 'dependency tools' used in one person's care plan. The dependency tools were designed to give staff an understanding of the level of support individuals required to assist them with their daily living needs. On one tool the person was assessed as having high dependency needs and on a second tool they were assessed as having medium dependency needs. We discussed these conflicting assessments with the registered nurse who agreed the scoring method was not clear and did not reflect the needs of the person. The same person was at risk of skin damage and their care plan showed they required particular creams to be used and regular repositioning. During our visit we saw the person was not assisted to reposition at the required frequency resulting in them sitting the same position for a number of hours. There was no risk assessment in place to demonstrate that the risk of skin damage and appropriate control measures had been fully considered. This placed the person at risk of developing pressure ulcers through poor management of this aspect of their care. We highlighted these issues to the registered manager during the inspection who agreed this would be addressed.

During our inspection we looked at people's personal emergency evacuation profiles (PEEP) that are used to assist staff and external professionals in the event of an emergency evacuation of the service. We found a number of the profiles we viewed lacked essential detail on how each individual should be supported in an emergency. One person's care plan showed they needed the support of two people to assist them but this was not clearly shown on their PEEP. This placed people at risk of not receiving the support they required in the event of an emergency.

Although people told us they received their medicines regularly and had no concerns, we found that medicines were not always administered and recorded safely. For example, we found the day before our visit, one person who required regular tests, followed by medicine to ensure continued stabilisation of an ongoing health condition, may not have received the test or medicine. There was no record of the test or administration in the person's medicine administration record (MAR). This placed the person at risk of a deterioration of their condition. Another person required a medicine in the form of a tablet to be administered once a week and we found the records showed this had not been administered for a period of two weeks out of the last month with no rationale as to why this was the case. The number of tablets left in the medicines trolley confirmed the person had not received this medicine.

Where people were prescribed medicines on an 'as required' basis we found there were not always protocols in place to assist staff in ensuring people received these medicines appropriately. For example one person's protocol simply stated a particular medicine should be given "for agitation" the protocol did not give any further information for staff to make an informed decision in relation to when they should administer the medicine. For other people who may require medicine for pain, the protocols lacked details of what signs and symptoms the person may display if they could not verbally communicate their level of pain. As the service relied on agency staff to cover a large number of shifts this lack of clear information for staff placed people at risk of not receiving their medicines consistently and as required.

Further examination of the MAR sheets for people showed that no medicines for the nursing residents had been signed for on the day prior to our inspection visit. Although we saw the blister packs containing people's medicine were empty indicating medicines had been given, the lack of signature had not been identified by the nurses on the two preceding shifts and consequently the registered manager was unaware of the issue until we raised it. This meant we could not be assured that people got their medicines as prescribed or were at risk of being given this again. We also found recording of temperatures for the one of clinical rooms and drug fridge showed checks had been missed during the last two months a total of eighteen times. This meant we were unable to ascertain whether medicines were being stored within a safe temperature range and remained effective to use.

One person's file showed they were receiving their medicines covertly (when medicines are concealed so that the person is unaware they are taking them). There was no evidence that consideration had been given to whether or not this was in the person's best interests and it was also unclear if covert administration of medicines was only used as a last resort. There was no evidence of regular reviews of this decision in the person's care plan and there was no guidance for staff about how to monitor the use of covert medicines. This meant the person could receive covert medicines inappropriately and may not be in their best interests.

All of the above information is a breach of regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Safe practices were not always followed when recruiting staff to the service. Whilst we saw the registered manager had used the Disclosure and Barring Service (DBS) to undertake criminal records checks on prospective employees, other pre-employment checks were not always in place. Of the six records we viewed three members of staff had not given references from their previous employers and the registered manager had not attempted to contact them to establish if there were any issues which may affect their decision to employ them. Where the registered manager had made a decision to employ a member of staff despite being made aware of concerns in their previous employment, they had not completed a risk assessment to show how they planned to oversee the person's performance once employed and mitigate these risks. As a result we found the safety of people who lived at the service was compromised by this poor practice.

This was a breach of regulation 19 of the Health and Social Care Act (regulated activities 2008) regulation 2014.

People we spoke with told us they felt safe at the service. One person said "I'm as safe as anywhere. The bedrails and padding keep me safe. I've had no falls recently. The staff are nice and kind. They are not rough." A relative we spoke with said, "I can talk to any staff about safety concerns but would go to the manager."

However, we received mixed feedback from people in relation to staffing levels. Most people felt more staff would be useful at busy times of the day. One person said, "There is never enough staff." However some people told us staff responded quickly when they asked for assistance. One person told us, "I don't have to wait long. Only a few minutes." Relatives we spoke with felt their relations received adequate care from staff when they received personal care and staff worked hard to ensure they responded quickly to their loved ones.

Staff we spoke with told us if staffing levels remained within the established levels of six care staff during the

day then they could meet people's needs. However, they told us there were times over the weeks prior to our inspection when the number of staff dropped below this and impacted this on their ability to give everyone the care they needed in a timely way. Staff told us the management team did try to cover the shifts if staff were off sick but this was not always possible. We looked at the staff rotas for the previous four months and saw there were times when staff were working with numbers of staff that did not meet the established numbers of staff agreed to meet the needs of the people who lived at the service. Staff told us the staff numbers had improved more recently and the registered manager told us they were trying to recruit further and use agency staff to fill the short fall.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they felt that staff had the skills to undertake their roles. One person said, "They are well trained and know what they are doing. All of the staff talk to me." Relatives we spoke with also felt the staff were trained for their roles. One relative said, "I think they are trained." The person went on to say staff knew how to approach and support their loved one.

The feedback from staff we spoke with about training was mixed, some staff told us they had not received updates on their mandatory training and felt they could benefit from further training in areas such as managing dementia and the Mental Capacity Act. Other staff told us they had some updates on their mandatory training.

However, the training matrix we viewed showed that a large number of staff required training updates in areas such as moving and handling, fire safety, health and safety, infection control and the Mental Capacity Act. Whilst the registered manager told us the training matrix was not up to date he was unable to assure us of the numbers of staff who had undertaken their updated training. We also discussed the 'train the trainer' role which provides staff with in-house training in areas such as moving and handling. The registered manager told us the people undertaking these roles also needed updated training. The lack of up to date training in these areas meant we could not be assured the amount and quality of training staff received was of a high enough standard to supply them with the necessary skills for them to fulfil their roles.

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.

Where people lacked the capacity to make a decision the principles of the MCA had not always been followed. Staff we spoke with were not always aware of the principles of the act or why it was in place. One staff member told us they did not know what test was undertaken to establish if a person had mental capacity but knew there was a way people were assessed. There were some staff who did have some limited knowledge of the MCA one member of staff said the mental capacity act was in place 'so people can have choice.' but they went on to say, "I could do with more training on this."

We found people's rights under the MCA were not always respected. We found that when people had been assessed to determine if they had the capacity to make a specific decision the majority of assessment had been undertaken by one member of staff and there was limited evidence of involvement of other people such as families or professionals. There were no records of best interests meetings and the mental capacity assessments lacked detail in relation to how decisions about people's mental capacity had been reached and they did not cover the different aspects of the individual's care needs in relation to their mental capacity.

We saw information in one person's care record from one person's family on how best to support the person who had fluctuating capacity. None of this information was added to the mental capacity assessment. The person's documentation in relation to MCA only covered their personal care, and the documentation lacked sufficient detail to show the decision reached for the person were the least restrictive option and in the person's best interests. This person's care plan also noted they were not always compliant in accepting their medicines. There had been no mental capacity assessment or best interest meeting to establish the least restrictive way to manage this. However, we saw another person's mental capacity assessments had included the views of health professionals and family.

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 saw that a number of people had applications made. However we saw an application for one person had only been made after a social worker who had been investigating a safeguarding issue had highlighted the need for DoLS to be applied for. This showed that staff had not been monitoring the person to establish any deterioration in the person's mental capacity and as a result may have been depriving them of their liberty unlawfully.

The above issues are a breach of regulation 11 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014

People we spoke with told us they were always given choices about their care. One person said, "Staff ask me if I want to shower." Staff spoke with them and checked they were happy to receive care. Staff we spoke with were aware of the need to ensure people consented to care. One staff member told us they always checked people were happy before providing care. They said, "I always ask them if they want me to do things." We saw a number of positive interactions that showed staff seeking consent from people before providing care for them.

People we spoke with told us they enjoyed the food at the service. One person "I like my food and drink. It's very good, I get a choice of meals." The person went on the say they enjoyed tea and coffee and had water in their room. Another person said "The food is good here, the cook comes and asks what I would like. I get plenty to eat and can eat by myself." One relative we spoke with told us their relation had put on weight since coming to the service. They told us the person had lost weight prior to coming to the service and told us staff had given the person milkshakes and food to help build the person up.

Staff we spoke with had a good understanding of the different diets people required and we saw people were supported to manage their meals. There were appropriate aids in place to assist people when they were required and staff gave the appropriate level of support in a kind way and at a pace to suit people.

However, despite this we found some people's nutritional needs were not always well managed. One person had lost 24 kg over the preceding twelve months. The person's weight and MUST (Malnutrition Universal Scoring Tool) score had last been recorded in June 2017. The person's care records stated they were to have their food and fluid intake monitored. The recording of the person's food intake was poor, records lacked detail in relation to the amount of food eaten. For example one record showed "sandwich" another record stated "porridge" and gave no indication of the amount to enable staff to monitor this effectively. The person was also meant to receive 1500 mls of fluid each day. However the charts we viewed showed they had not been totalled up each day and on checking the charts further we found the person had not taken the recommended amounts of fluids on any of these days. This information was not reflected in the person's

care plan. We saw in their records a health professional had advised that they commence taking dietary supplements. There was no evidence that this had been actioned and it was not reflected in their care plan or their MAR sheet. This put the person at risk of further weight loss and there was no evidence in the person's file that the cause of the weight loss had been investigated.

Another person's records showed they had lost just under five kg in weight over a period of six months. They had also not been weighed or had their MUST assessment completed since June 2017. This was despite recommendations from a health professional recorded in their care record for regular monthly weights and daily monitoring of the person's food intake. We viewed the person's charts and found there was also a lack of detail in the recordings of their intake.

This shows a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Despite some testimonies of good practice, our observations of people's records showed that people's health needs were not always well managed. Recommendations from some health professionals had not been carried out. Also some aspects of care discussed above show that the service did not always manage people's health needs safely.

However people told us they were happy with the way their health needs were managed. One person told us, "I'd ask a senior carer if I needed a GP," they told us they had a health condition that required the application of a particular cream and the staff supported them with this. A relative we spoke with told their relative was prone to recurring infections, they told us the staff would call the doctor when required and said, "This happens quickly."

Staff we spoke with were clear about how they managed people's health needs. Staff told us they would speak to the senior care worker or the nurse who would assess and call out the relevant health professional. One member of staff said, "Yes (senior staff are responsive) and I would raise things to make sure people see the health professionals they need."

During our visit we spoke to two health professionals visiting the service and observed staff working with other visiting health professionals. There was a good relationship between the staff and health professionals and one health professional told us staff were responsive and acted upon advice from them.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they were happy with the way they were cared for at the service. One person said, "I love the place and give it 10 out of 10." Another person said, "You get looked after properly. Most staff know my story. I talk a lot." Relatives we spoke with told us they were happy with the way staff provided care for their family member. One relative said, "I have not found a better place for [name] locally."

Staff we spoke with told us they enjoyed working with the people they cared for. They felt their colleagues were kind and respectful towards people. One member of staff said, "We work together and support each other so we give people the best care we can."

Our observations of staff interactions with people were positive. Whilst they did not have a lot of time to sit to talk with people we saw they responded to people in a kind and familiar way. As staff passed through the main lounge when working, they generally spoke briefly with people. We saw these interactions were tailored to suit people's different needs as staff enhanced their communication by touch, ensuring they were at eye level with people who were seated and altering their tone of voice appropriately. It was clear staff knew the needs of the people they supported when we discussed a number of people with them. We asked staff about people's care and choices, and the staff we spoke with showed a good knowledge of these needs.

People we spoke with told us they were not aware of their care plans, only one relative we spoke with told us they were aware of the care plan in place for their loved one. One relative said, "I think I saw it (care plan) long ago.

We did not find any evidence to show people or relative's views had been incorporated into their care plans. There was information in people's records to show that whilst relatives had expressed views on their relations' care these views had not been incorporated into the care plans. We discussed this with the registered manager who told us that there were regular conversations and the staff did undertake care reviews with people's relatives when completing and updating the care plans. However this was not evident in the plans we viewed.

The registered manager told us people's diverse cultural needs would be catered for at the service. We saw where one person had wanted to practise their faith by going to their place of worship this had been accommodated for as long as the person had wished. Staff also told us there was a regular monthly religious service at the home for people who wished to attend. No one at the service was using an advocate and we were unable to find any advocacy information for people on display at the service or in the service user's guide. An advocate is a person who is a trained professional who supports, enables and empowers people to speak up. The registered manager told us there were a number of people whose relative's did not visit them so the lack of information on the availability of an advocate meant these people may not have the support they needed to air their views on their care.

People's privacy and dignity was well managed at the service. People told us they had no concerns around

this area of their care. One person told us, "Staff always knock on the door, they use the hoist skilfully and sometimes help me get dressed. The curtains and doors are closed." Relatives were also happy with the way their loved ones' privacy and dignity were managed. Relatives we spoke with felt staff spoke respectfully with their relations and one relative said, "They (staff) knock on the door before coming in unless the door is open. The curtains are closed when [name] is dressing."

Staff we spoke with showed a good understand of their role in supporting people to maintain their privacy and dignity. One member of staff told us they were discreet when talking with people about their care. They went on to say, "I don't like people to feel patronised, I talk to them the way I want to be spoken to."

Our observations of staff's interactions with people supported what we had been told. We saw and heard when doors to people's rooms were closed staff knocking and identifying themselves. Doors were closed during personal care and when staff were leaving a room they checked if the individual wanted the door left open or closed.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with talked positively about the care they received. Both they and their relatives felt staff had knowledge of their individual needs. One relative we spoke with told us, "[Name] is extremely well looked after. It is hard for them to remember their past and staff have triggers to get them to remember."

However, we found some of the care plans we viewed lacked updated information for aspects of some people's care. There was also conflicting information in some of the care plans. For example, one person's care plan showed two different reasons for the use of a urinary catheter for that person. As the person had been having some issues with their catheter the lack of clear information for staff could result in the person receiving inappropriate treatment. Their care plan also lacked information for staff on how to assist the person with the daily care of the catheter. The person had also been highlighted as having poor skin integrity but their care plan lacked an assessment tool to assist staff to manage this aspect of the person's care.

A further person's care record we viewed showed that information supplied by health professionals related to pressure area care was not reflected in their care plan. Particular regimes and monitoring of the person, had not been recorded as being undertaken by staff. Documentation viewed, reflected that the person was not receiving the care they required. The person required repositioning every two to three hours. Staff we spoke with were aware of the regime and told us they were repositioning the person every two to three hours, however the daily records did not support this. The registered manager told us they would ensure that this person's records were updated appropriately to accurately reflect the care and support they received from staff.

The person also required a wound to be redressed regularly, however the care plan was not clear as to how often this should take place. The staff nurse we spoke with told us this should take place every other day but the daily records showed the wound had been dressed on one day and the day following day, but had not been dressed for a period of five days. One entry in the daily notes showed the person had been in pain when the wound was redressed. However, there was no information in the person's care plan on how this pain could be managed when their wound was redressed. The lack of clear, individualised documentation placed people at risk of receiving inconsistent and unsafe care

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Some staff we spoke with also told us they felt communication around the changes in people's needs could be improved. The staff received a daily handover but if they had been off work for some time they were not always kept up to date with people's changing care needs. One member of staff said, "We rely on each other to keep up to date." Another told us, "Communication is terrible, I had a week off and didn't get chance to read the handover book." Whilst staff told us they did view the care plans when they wrote the daily notes, care staff did not write in all the care plans as nurses took the responsibility for completing some of records. This meant care staff may not have regularly viewed changes in these care plans. This, with the lack of

effective ongoing communication processes in place meant staff may not always have the most up to date information to provide people with the current care they needed.

People were not always supported to follow the social activities of their choice. In the three month period leading up to our visit there had been no activities co-ordinator available at the service. One person told us, "I don't have a lot of hobbies, I do cleaning. There are some activities written up on the wall, not a lot." A relative told us, "[Name] joins in the bingo and sometimes musical entertainment. There has been a bit of a gap (in activities). A new activities co-ordinator is starting soon."

On the day of our visit there were no group activities offered to people. The activities co-ordinator told us they worked four hours a day, four days a week but the service was employing a further activities co-ordinator to work a further 12 hours. The activities co-ordinator told us she did offer some group activities but as some people preferred to stay in their rooms and a large number of people required two members of staff to support them, it was difficult to offer a lot of group activities. The activities co-ordinator tried to spend a bit of time with people who stayed in their rooms but explained this could mean this was as little as ten minutes per day. This meant a large number of people who were nursed in bed were at risk of becoming isolated.

People we spoke with told us they would feel comfortable raising a concern or complaint to the registered manager. One person told us, "I would go to the manager, but I am not a complaining person." A relative we spoke with told us they had raised a concern about administration some time ago and this had been resolved for them.

However despite being told by the registered manager they had not received any complaints, we viewed complaints from one family in relation to their relative's care. The information was recorded in their care records. It was noted the complaints had been passed onto the registered manager. One complaint was in relation to the person's personal care. Another complaint had come through the safeguarding team following which an investigation had been undertaken. These complaints had not been responded to by the registered manager or considered as complaints and responded to as per the company's complaint procedure. This showed a lack of understanding by the registered manager of their responsibilities for the people who use the service and relatives to address their rights in relation to their care.

Inadequate

Is the service well-led?

Our findings

Whilst the people told us they found the registered manager a visible presence in the service no one we spoke with knew the provider of the service. One person we spoke with said, "I sometimes see the manager coming around. If you want him you can call him." A relative we spoke with told us, "I can talk to the manager and am happy with the staff. He (manager) is easy to talk to. If it is a medical issue I would go to the nurse."

Staff we spoke with echoed these views. Some staff members had never seen the provider at the service and others told us they had seen them once but had never been introduced to them. One member of staff said, "The manager is ok, never had any problems. I never see the boss (provider), the manager is left out on his own." Another member of staff told us, "I can go to (name- manager) about the residents. I have only seen the owner once I don't feel the owner is bothered about the staff."

Staff told us they did have observations of their practice by the management team but they had not received any regular supervisions or appraisals. Prior to the inspection, information we received showed that staff did not always feel comfortable in raising issues of concern in relation to management of the day to day running of the service. This was supported by some comments made by staff on the day of our inspection. It was clear the issue had affected staff morale at the service and we fed this information back to the registered manager who told us he would try to address this issue.

Additionally there was a lack of clinical supervision of the registered nurses employed by the service. Whilst we saw evidence of a supervision undertaken by the clinical nurse lead for one of the registered nurses, we could not find any evidence of training in clinical supervision for the clinical lead or how they themselves were supported with clinical supervision. It is requirement of a registered nurse to show they undertake regular reflective discussion of their practice and their employers are required to support this. Regular clinical supervision with professionals who have received adequate training in this area would be an effective way to manage this.

Staff told us there had not been any regular staff meetings during the last year and the registered manager confirmed they had only held one meeting recently to feed back to staff on issues raised to them by the local authority. Staff we spoke with did not feel that they had a forum to raise ideas to improve practice. This showed a lack of engagement with staff by the whole management team.

During our inspection we discussed the lack of any meaningful quality audits with the registered manager. They told us there had not been any regular auditing processes relating to medicine's management, care plans and risk assessments during the last year. We saw a health and safety audit dated 2015 and the registered manager confirmed with the maintenance person that this was the last full health and safety audit undertaken by the service. Whilst the handy man undertook regular checks of the rooms at the service and picked up issues raised to him there had been no full comprehensive audit undertaken in 2016 or 2017. This lack of regular systematic auditing had impacted on the registered manager's ability to identify and effectively manage incidents and issues related to the safe care of people in his care. This lack of oversight

also extended to the provider who rarely visited the service and did not undertake any quality assurance audits and meant the provider had not identified or addressed issues of concern we found at our inspection. Such as the lack of robust up to date risk assessment for people, lack of environmental audits, poor staff recruitment processes, lack of regular supervision of staff and a lack of analysis of falls.

We discussed the ways the registered manager monitored falls that people had in the service. They told us they looked at each person's falls individually and recorded this information in their care plans with the actions they had undertaken to manage the risks to the person. However the registered manager did not undertake an analysis of the number of falls in the service each month to establish trends to assist them review measures in place or staffing allocations. A thorough analysis of falls looking at the times, areas where falls happen, staff levels and allocations, and measures already in place would give the registered manager an oversight that would assist them in reducing any trends. The failure to have systems in place to analyse patterns of falls resulted in us identifying people through our inspection who had suffered multiple falls that had at times had serious consequences for them. The lack of this regular analysis showed that as well as the lack of effective measures in place to manage some of the individual risks to people meant there was a lack of effective governance in relation to managing risk in the service.

The provider had also commissioned a recent fire safety audit with an external provider we saw there were a number of outstanding actions from this audit that the registered manager had raised with the provider. However he had not received the financial authorisation he required to address the actions. This showed a lack of engagement from the provider to support the registered manager ensure the environmental safety for the people who lived at the service.

The above issues identified the provider was in breach of regulation 17 of the Health and social Care Act 2008

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the mental capacity act were not always followed as best interest meetings had not always been held for people who lacked mental capacity.