Caring Homes Healthcare Group Limited

Garth House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Garth House is registered to provide nursing care and support for up to 42 older people whose primary needs are nursing or who may be living with dementia. The home is set in its own grounds and located in a residential area of Dorking. There were 27 people living in the home on the day of inspection.

The service did not have 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 and associated Regulations about how the service is run.

The inspection was unannounced and took place on 2 August 2017.

When the service was last inspected on 14 and 31 March 2017 we highlighted areas which required improvement. During this inspection we saw limited improvement to people's care however we also identified that some areas had not improved.

The lack of good leadership after the departure of the registered manager had an impact across all of the five key areas we looked at. It affected the safety of the home as staffing levels had not always been maintained at a safe level; how effective the home was at meeting people's needs; how caring and responsive staff were; and how well the home was led. We have identified five breaches in the regulations. This is the same number as our last inspection, with four being repeat breaches, showing that a lack of leadership was failing the people who lived here. You can see what action we have asked the provider to take at the back of the full version of this report.

When risk of harm had been identified people were not always supported to be kept safe. People's nursing needs were not always safely monitored and staff did not respond safely to changes in people's health needs, particularly when they lost weight. For some people we found that call bells and drinks were out of reach which put them at risk.

People were not always supported by enough staff. Staffing levels had consistently not been met over the previous four-week period prior to the inspection. Staff had to be very task orientated and did not have time to ensure people were safe. We had to intervene on two occasions to ensure people received safe care. Staff recruitment processes were safe. Appropriate checks, such as a criminal records check, were carried out to help ensure only suitable staff worked in the home.

People were not supported in line with the principles of The Mental Capacity Act 2005. Staff were not always clear about consent and how it should be obtained from people. Appropriate applications had been made under the Deprivation of Liberty Safeguards (DoLS).

People were not always treated with dignity and respect. We observed times when staff supported people in

an undignified way and spoke about their healthcare needs which could be overheard.

Since the last inspection there had been further quality assurance systems put in place to monitor the service provision. Despite this the audits still failed to highlight the shortfalls at the service some of which had been highlighted in previous CQC reports.

Since the last inspection unsafe equipment had been taken away and replaced. Staff had a good knowledge of people's mobility and were seen to support people safely in this regard.

People were supported by staff who understood the signs of abuse and their responsibilities to keep people safe. Safeguarding concerns had been appropriately reported. Since the last inspection on 14 and 31 March 2017 the provider had referred incidents and accidents to the local authority for further investigation under their safeguarding procedures.

The analysis of accidents and incidents was managed effectively. Measures were in place in order to minimise risk to people or to reduce their reoccurrence. People's care and treatment would not be interrupted in an emergency as there were procedures in place to manage this.

People were supported with the medicines safely. Staff were confident and had the knowledge to administer medicines safely. They knew how to support people to take their medicines and to keep accurate records.

Improvements had been made to staff support. People were supported by staff who received an induction to the service and regular supervision. Staff said they felt supported. Staff felt they received the training and support they needed to meet people's needs effectively however this was not always carried through into practice.

People were supported to eat meals of their choice and said the food was good. Staff referred people to healthcare professionals for advice and support when their health needs changed.

People knew who and how to complain and were confident any complaints would be listened to and action taken to resolve them.

The acting manager understood their responsibilities in terms of notifying CQC of significant events at the service. Staff supported people in line with the organisational values as support was centred around increasing people's independence.

During this inspection we have highlighted five breaches of regulation. Please read the full version of the report to understand what action we have asked the provider to take.

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 protected from harm as people were not being supported in line with highlighted risks.

People were not supported by sufficient staff to meet their needs. The provider had a good recruitment process in place.

Staff reported accident and incidents and staff understood how to report suspected abuse.

Medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not always protected because staff did not always follow the principles of The Mental Capacity Act.

Staff had the skills and training to support people's needs and staff felt supported..

People were served a variety of meals which they were complimentary about.

People had access to health and social care professionals who helped them to maintain their health and well-being.

Is the service caring?

Requires Improvement

The service was not always caring.

Although we saw the majority of staff were caring towards people they did not always treat people with dignity and respect.

Staff did not have the time to always support people in a caring way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had the opportunity to join in with a variety of activities however these activities did not always meet the needs of people, particularly those being cared for in bed.

People's care was reviewed and involved people and those close to them where appropriate.

When they could be staff were responsive to the needs and wishes of people.

People and relatives knew how to make a complaint and were confident it would be acted on.

Is the service well-led?

Inadequate

The service was not always well led.

There had been a number of temporary managers in post which has led to a lack of oversight on the issues in the service. A manager had been recently recruited but had not yet applied to be registered with CQC..

Quality assurance systems had failed to address previously highlighted concerns and there were continued breaches of regulations identified.

People said the service had a positive culture.

Garth House

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 2 August 2017 and was unannounced. The inspection team consisted of two inspectors, a nurse specialist advisor and an expert by experience. An expert by experience is someone who has experience supporting people and is used to gain their views of their support.

Before the inspection, we checked the information that we held about the home and provider. This included statutory notifications sent to us about incidents and events that had occurred at the home. A notification is information about important events which the provider is required to tell us about by law. We also reviewed any complaints, whistleblowing and safeguarding information from relatives and staff. A provider information return (PIR) was received which was used to aid the inspection planning process. We used all of this information to plan for the inspection.

During the inspection we spoke with 10 people, seven relatives, three care staff, two nurses, the compliance nurse and a visiting care professional. We also spoke with an activity coordinator, the manager and district manager. After the inspection we requested more information from the provider, which was sent to us.

We observed care and support being provided in the lounge, dining areas, and with people's consent, we visited people in their bedrooms. Some people had complex care needs which meant some had difficulty describing their experiences of living at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also observed people receiving their medicines and spent time observing the lunchtime experience people had.

We reviewed a range of records about people's care and how the home was managed. These included 11 people's care records and medicine administration record (MAR) sheets and other records relating to the management of the home. These included staff training, six employment records, quality assurance audits,

accident and incident reports and any action plans.

Requires Improvement

Is the service safe?

Our findings

During the last inspection we highlighted concerns to people's safety. We found there was a failure to ensure that risks to people's safety were identified and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) 2014. During this inspection we found some improvements had been made in this area however there was still more improvement needed to ensure people were safe.

People who were assessed as needing a call bell to summon help from staff did not have them to hand. We saw that seven people on the morning of the inspection were unable to reach their call bell. This meant they could not use the bell to call for assistance when needed. When asked about their call bell one person said, "No I can't get to it. It's sometimes like that." This puts people at risk of not receiving care when they required it. We spoke to the acting manager about this concern and noted that improvements had been made in the afternoon however this should have been identified by staff and management.

People were at risk of dehydration. People who were cared for in bed and who had been assessed as being at risk of dehydration were not able to reach drinks that had been left for them. A relative said, "That's something that could be better. We'll often arrive and her water never seems near her. Even on hot days and the windows are not even open." People had monitoring charts to record their fluid intake which should have a target amount to guide staff on how much fluid each person should get. This was not recorded which meant staff were unaware of how much people should drink to maintain their health. Although there were no signs that people were dehydrated this put people at risk of their health deteriorating. This was something that we had highlighted in our last inspection report.

People were at risk of choking as they had not always received the correct diet to meet their swallowing needs. One person was assessed as needing a soft diet as they were at risk of choking. Their care plan also indicated that they required assistance while eating to keep them safe. On the day of inspection we observed that they were eating their lunch alone in their room. They had been served pork to eat, which was against their dietary guidance. This put the person at risk of choking. We have gained reassurance from the registered manager that this person is now receiving the correct diet and support at mealtimes.

During the last inspection the risk of malnutrition had not always been recognised or acted upon. There had been improvements in the support people received at meal times. Despite this where people were losing significant amounts of weight no action was taken, for example they were not referred to a GP or dietician. Three people who were assessed as needing to be weighed weekly were being weighed monthly. One person's care plan indicated they should have a nutrition chart to monitor their food intake but they did not have one in place. This issue was also highlighted in the last inspection so no improvement had been made in this area.

People who were cared for in bed were at risk of falling. Two people who had been assessed as needing bed rails to keep them safe did not always have bumpers on the rails. This put these people at an increased risk of entrapment. When we asked staff about this we were told that the bumpers were being washed. We notified the acting manager about this who immediately ensured bumpers were put on.

Failure to assess and mitigate risks to people is a continued breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) 2014.

Improvements had been made in pressure area care. People at risk of developing pressure ulcers had care plans, which staff understood and followed. When needed people had a booklet that evidenced the support they received to manage pressure areas and the progress made to improve them. A relative said staff managed their loved ones pressure area well. We also saw a compliment from a care professional that praised the service for the wound care a person received.

Improvements had been made in moving and handling practices. Staff had a better understanding of people's moving and handling guidance and we observed safe practice during the inspection. Other risks to people had been identified and were being appropriately managed, such as skin integrity and diabetes.

Accidents and incidents were now being reviewed to monitor trends and to take steps to reduce the likelihood of them reoccurring.. One person had a fall so their support was reviewed and equipment to aid their mobility was introduced. A relative said, "I feel he is safe. He has his crash mats and his chair helps. Staff do all that they can to reduce the risk of him falling."

During the last inspection there were not always enough staff to meet people's needs. At this inspection, a relative said, "There are enough staff. At one time it was a problem because there were a lot of new faces, but it's more consistent now." However we found staffing levels still impacted negatively on people's care and support.

During the inspection there were two occasions when we had to step in to ensure people received safe care. One example was when someone said they were in pain and the other was when a person was positioned unsafely while eating. Staff told us that two people were in bed for long periods of time because it reduced the workload for staff as they needed hoisting. Another person who was in their room was heard shouting for the majority of the afternoon. Staff understood that when this person had company they would stop shouting. We observed the difference in this person's behaviour when staff were with them. Despite knowing this staff only had the time to give the person brief visits that were not long enough to give the person reassurance. This caused the person increased distress.

The manager informed us the staffing levels reflected the needs of people. They told us they used a dependency tool to determine how many staff they needed on shift to meet people's needs. There were two nurses and five care staff in the morning and two nurses and four care staff in the afternoon.

We requested the staff rotas for the previous four weeks. This was provided and following analysis we identified that the service had not consistently maintained safe staffing levels as had been assessed using their own dependency tool. On seven occasions there were less than the required nursing staff working and on 19 occasions there were less than the required care staff working over the preceding four-week period.

Failure to maintain safe staffing levels is a continued breach of Regulation 18 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected by safe recruitment procedures. The provider carried out appropriate checks to help ensure they only employed suitable people to work at the home. Staff files included information that showed checks had been completed such as a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

During the last inspection people were not safe because staff did not always understand their roles with regard to safeguarding people from abuse. During this inspection we found improvements had been made in this area. Staff had the knowledge to recognise and report suspected abuse. One member of staff said they would report any concerns to the manager. We saw that the manager had reported safeguarding concerns when it was appropriate.

During the last inspection we found some equipment was unsafe and the standard of decoration and cleanliness was variable. Improvements had been made and this had been addressed. People used equipment such as hoists and wheelchairs that were regularly serviced. Equipment that had been identified as unsafe had been removed. People's rooms were clean and the provider continued to work through improvements to the decoration of people's rooms. Several people said they liked their rooms and felt comfortable.

During the last inspection medicines were stored in a room which was too hot. We saw that medicines were now stored at a safe temperature and this was being monitored. People received the medicines they required. The medicines administration record (MAR) charts were completed properly, without gaps or errors which meant people had received their medicines when they needed them. Each MAR held a photograph of the person to ensure correct identification of individuals and there was information on any allergies and how people liked to take their medicines. People had their medicines given to them in an appropriate way by staff. For example, with food or after food as directed.

Medicines given on an as needed basis (PRN) and homely remedies (medicines which can be bought over the counter without a prescription) were managed in a safe and effective way and staff understood why they gave this medicine.

People would continue to receive appropriate care in the event of an emergency. There was information and guidance for staff in relation to contingency planning and we read each individual had their own personal evacuation plan (PEEP).

Requires Improvement

Is the service effective?

Our findings

At the last inspection effective action had not always been taken where people lacked capacity to consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service was still not working within the principles of the MCA. During the last inspection we found best interest decisions had not been undertaken for people who had bed rails in place. Bed rails can restrict a person's movement and people, or their representatives if legally entitled, should consent to their use. People had mental capacity assessments and risk assessments in place but there was still no information detailing why it was in their best interest to have bed rails. Some people had consent forms in place for their bed rails that had been completed by a relative. Despite this the manager and staff were unaware if the relatives had legal authority to make these decisions on behalf of people.

People's capacity to make decisions was not being made in line with the MCA. Mental capacity assessments that had been written since the last inspection were not decision specific. This meant that people were not getting their capacity assessed for each decision in their life but instead a 'blanket' approach was taken which meant people's consent about their care and support was not always obtained.

People were being supported by staff whose understanding of consent varied. One member of staff said, "I always talk to the person throughout the process. I don't always receive a formal consent. My role is to make sure the hygiene is kept up so if people can't make decisions or I don't get consent then I would still go ahead." When asked about how they encouraged people to make a decision another member of staff said, "I will do things like show people options. For example, I got out a top for (name) and showed her and she didn't look happy. I took out another top and her face changed and this showed me she wanted to wear that top." A third member of staff told us they did not know much about mental capacity.

Failure to act in line with the MCA is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Applications for DoLS authorisations had been made for 14 people. DoLS applications had been made for the lock on the front door and bed rails. Staff were supporting people in line with these applications.

During the last inspection not all staff employed were familiar with the home or people's needs. During this inspection we noticed an improvement in staff knowledge. They appeared confident in their roles. One person said, "Some are better than others but they all do the job well enough." Another person said, "I think they generally seem to know what they're doing." In a recent local authority quality assurance visit it states,

'All staff were confident, friendly and visible during our visit.'

People were supported by staff who were trained to meet their needs however the learning from this was not always put into practice. All new staff undertook induction training in line with the Care Certificate and were only allowed to work alone when they were assessed as competent to do so. Mandatory training included health and safety, food hygiene, fire safety, dementia awareness, oral hygiene, MCA awareness and manual handling which had been updated the previous week. Staff praised the induction at the service. One member of staff said, "I really enjoyed the induction. I was put with a senior straight away and supported by her and others." Another member of staff said the induction was, "Quite good. There's a lot of learning on the job." A third member of staff told us they were working towards their care certificate and were enjoying this.

Nursing staff received clinical training that included tissue viability, catheter care and medicine updates. They told us they had support with revalidation in order to renew their professional registration. This is a process set by the Nursing and Midwifery Council (NMC) that all qualified nursing staff have to undertake in order to be allowed to practice in the UK. The corporate clinical nurse had undertaken clinical supervision on all the nurses prior to the inspection.

People were generally satisfied with the meals that were offered to them. One person said, "I wouldn't eat here if wasn't good." Another person said, "The foods good, it's not boring." A third person said, "There's a main meal and it's nicely cooked."

Menus were seasonal and reviewed regularly. These were displayed on dining room tables which showed people what was on the menu that day. These menus were also in picture form so people who were unable to read to tell what was on offer. There was a choice of starter followed by a main course. Lunch was served in different areas in the home. Some people had their meal in the main dining room whilst others chose to eat in the lounge or smaller dining area.

People had access to health and social care professionals, who helped maintain their health and wellbeing. Staff responded to changes in people's health needs by supporting people to attend healthcare appointments, such as to the dentist, podiatrist, opticians or doctor. Care records showed people's health care needs were monitored and recorded visits made by other health care professionals. People were registered with a local GP who visited the home weekly or more frequently when required to do so. When asked about the service a visiting GP said, "Everything is fine. No concerns here. They work well with us."

One relative we spoke to said in the past there had been two occasions when staff had not picked up that their loved one was unwell. The relative said, "Since then I have had much better communication from the nurse who has been very good at keeping me informed and recognises and greets me which didn't happen before." A member of staff said, "Recently we have seen input from pharmacist, pressure care specialists, CCG dieticians in order to improve care". We observed staff responding effectively to unforeseen circumstances. During the day of inspection two people were taken unwell and the staff ensured that they received prompt medical attention.

Requires Improvement

Is the service caring?

Our findings

People were positive about staff and the care they received. One person said, "They're very good and treat you like human beings." Another person said, "They are so lovely and helpful." A third person explained to another, "It's nice here don't you think, just like we said everyone treats us well." We saw compliments from relatives that described the staff as, 'Kind.' One compliment thanked staff for, 'Cheering us both up in our down moments.' A recent local authority quality assurance report read, 'Residents appeared comfortable, well-groomed and appropriately dressed for the weather.'

During the last inspection there were times during the day that staff could not spend time with people. During this inspection people said that staff were approachable and they were there to meet their needs. Although the majority of staff were caring in nature they were task orientated and this affected the care we observed. Staff were observed to be very busy and still did not have time to spend with people. When we asked a member of staff what could be improved at the service they said, "Interaction. I don't think staff do enough."

We observed other staff interactions which highlighted the service had not improved as much as we would have expected. In the morning a nurse entered the lounge and without communicating or gaining consent started adjusting people's clothing and smoothing their hair. Some of these people were asleep at the time. We observed staff on occasions did not knock on people's doors or wait for a response before entering people's rooms. We observed a nurse walk into someone's room to support them and not acknowledge the person. During our Short Observational Framework for Inspection (SOFI) we noted that one person was not communicated to by staff for one hour and 40 minutes. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We found these lack of interactions to be uncaring. A member of staff said, "I would like to do things properly but don't always find the time to do so. I would like to treat people like I would like to be treated."

People were not always treated with dignity and respect. We observed a nurse supporting a person to have a drink. They did not communicate with them and pushed the person's head up whilst holding them under the chin whilst they drank. This did not look very comfortable and was not very dignified. It was only when the relative came in the nurse went and got a cushion to position the person more appropriately.

Another person in bed had a large spillage of food over their clothes. This was because staff had not supported them to sit upright, and a table was not in the correct position for them to eat in a dignified way. We had to go and find a member of staff to clean this. We also observed that when a person was hoisted a privacy screen was used. We spoke to their relative who told us staff did not normally use this and questioned what it was for. The relative said, "Well other ladies get hoisted and moved but they don't use them for those others."

Failure to treat people with dignity and respect is a beach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at times supported in a caring manner. Despite the pressure of time we saw on occasion that staff made time to support people in a caring way. We observed a member of staff reassure a person about their broken hearing aid. We observed one person ask a member of staff to find something in their room. They replied "Okay, of course I'll go and find it for you," and immediately responded. We also observed a member of staff making a person comfortable and showing a person where the toilet was located when they said they had forgotten. These interactions were both positive and caring in nature.

During the inspection information about people living at the home was not always shared sensitively or discretely. At lunchtime staff spoke loudly to each other about one person's healthcare needs. Other staff spoke respectfully about people in their conversations with us, they showed their appreciation of people's individuality and character. Staff knew people's background history and the events in their lives that were important to them.

People were supported to maintain their relationship with friends and families. People and relatives told us about a recent summer barbeque which the manager had organised. Everyone said they enjoyed the event and it was described by one relative as, "Raising the morale," of people and staff.

People who were able to were involved in their care as much as possible. When people were admitted to the home they had been asked about things that mattered to them. For example what their likes and dislikes were, how they liked to spend their time, where they ate their meals. We observed people being supported in line with their assessments. People were supported to be as independent as possible. People told us that they chose what time they got up and if they wanted to take part in activities. People were seen to be encouraged to walk on their own when they could.

Requires Improvement

Is the service responsive?

Our findings

During the last inspection people did not always receive care that was responsive to their needs and there were not always enough activities for people. We saw that improvements had been made in this area however there are still further improvements to be made with the activities available to people.

People were provided with opportunities to take part in a range of activities of their choice. The service employed a part time activity co-ordinator and they were hoping to recruit another. Activities on offer included musical bingo, sing-a-longs, skittles and music therapy. During the inspection we observed a music quiz and a game of skittles. In the afternoon there was a music therapy session taking place. Although people were positive about the activity co-ordinator there was mixed views on the activities on offer. One person said, "I quite like the exercise classes." Another person said, "I love poetry and we sometimes do that but there's not enough time for me do to it as much as I'd like."

A relative said, "X finds some of the activities and entertainment a bit childish. X's friend who is also in a home comes to visit and where she is it's a smaller place. The friend notices how much more one to one residents get where she is. That's lacking here." Staff told us, "For those who are bedbound I think we could do more. People tell me they are lonely. There are two people in particular who get very low because they are lonely and they could do with more quality time."

We asked the activity co-ordinator about the activities on offer to people cared for in bed. She said that she went around in the morning for two hours and visited people in their rooms. When we asked how much one to one time people received she said, "About 15 minutes once or twice a week." The activity co-ordinator said, "To be honest they would all benefit from one to one but it's very challenging." This highlighted a lack of opportunity for people who are cared for in bed and could make them at risk of becoming isolated.

We recommend that the registered provider reviews the activities on offer particularly for people who are cared for in bed.

Improvements had been made to people's needs assessments. Before people moved into the home a comprehensive assessment of their needs was completed with relatives and health professionals supporting the process where possible. The assessment process meant staff had sufficient information to determine whether they were able to meet people's needs before they moved into the home. Once the person had moved in, a full care plan was put in place to meet their needs which had earlier been identified in the initial assessment. These care plans were more person centred than they were during the last inspection. People's care plans were regularly reviewed with people. A relative confirmed that their loved one was involved in their review by saying, "We did sit down and chat through everything about X's care and X was fully involved."

People were supported by staff who had a knowledge of person centred support. Staff were able to tell us about people's preferences without referring to their care plans. For example, staff were able to inform us how to support someone to become less distressed. There was information concerning people's likes and

dislikes and the delivery of care.

Residents and relatives meetings took place where people were encouraged to air their views and receive feedback and information about what was happening in the home. We saw that when suggestions were made then the manager responded. In the recent relatives meeting it was suggested that the nurse's station have a bell so people could call them. This had been implemented. Another relative raised that they were concerned with the bed that their loved one was using. The manager ensured that this was replaced with a new one.

People were made aware of their rights by staff who knew them well and who had an understanding of the organisations complaints procedure. People and relatives knew how to raise complaints and concerns. When received, complaints and concerns were taken seriously by the registered manager and used as an opportunity to improve the service. There had been two complaints in the last 12 months. One of which was about the cleanliness of someone's room. This complaint had been investigated and the manager organised a deep clean of the room.

Inadequate

Is the service well-led?

Our findings

The lack of a consistent and registered manager at the home impacted across the five key questions that we ask: is the service, safe, effective, caring, responsive, and well led? The actions taken by the provider after our last inspection had not been effective at addressing all the previous inspection concerns.

The provider had submitted a plan to us after the last inspection detailing how they would address the issues we raised, and by when. At this inspection we continued to raise concerns in many of the same areas, even though the provider had told us in their action plan they would be addressed. For example the action plan had recorded that 'Care plans to reflect risk assessments'. The date this should have been completed was 30 June 2017. We identified that risk assessments were still not always up to date. This failure to complete the actions as agreed demonstrated the home had not been well led.

Senior management quality assurance audits implemented since the last inspection had failed to highlight the continued shortfalls in people's care. They had not identified where poor staff practice had left people unable to reach call bells; that staffing levels had fallen below the minimum specified by the provider as being safe; or that risks to people's health and safety had not been adequately addressed. They had not identified that there was a risk that people's rights under the Mental Capacity Act (MCA) would not be met, because the requirements of the Act had still not been successfully implemented by management. The issues around the MCA had been identified in the last two inspection visits, demonstrating that management had not been effective at addressing our concerns.

During the last inspection we found the management team did not have a comprehensive oversight of the home. During this inspection we found that the manager had implemented a number of audits including a health and safety, medicine and care plan audit. We saw that the regional manager also undertook an overall audit of the service based on CQC methodology. Since the last inspection the provider had also implemented an action plan on how they were going to improve the short falls highlighted at the last inspection. Although overall there had been some improvement in people's care since the last inspection more improvement was expected based on the information they gave us in their action plan.

Failure to have effective systems in place to improve the service is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the last inspection staff told us that morale had been affected by several management changes and they felt unsupported as a result. During this inspection we found that improvements had been made in this area and staff said they felt supported by management.

Despite this the service had been without a registered manager since February 2017 although one had been recently recruited. The provider had employed several managers since then, some on a short term basis, but none of them had been registered. The current manager had been at the service for six weeks but was not being registered with us as she was only in position on a short term basis until a new manager started. A relative said, "If I had one criticism it is that we need a manager desperately. However, despite not having

one the home has continued to operate."

The provider had recently brought in a clinical compliance nurse to help improve the clinical oversight of the service. They were enthusiastic and had already made improvements and highlighted areas that needed to be prioritised. She informed us that she was working closely with health professionals to identify areas of improvement and had already created a plan of actions in improve people's clinical care. She was already aware of the shortfalls in the fluid management and had plans to improve. An improvement plan highlighted actions taken to ensure people's air mattresses were set at the right settings. During the inspection we found no concerns in the management of people's mattresses.

During the last inspection there was a lack of organisation which impacted on the care provided to people. Improvements had been made in this area. Staff were now aware of what was expected of them or where they would be working as they were encouraged to be involved in the service. We saw that the manager had implemented several meetings to ensure communication improved at the service. For example there was now a daily '10 at 10' meeting where senior staff spoke about what was happening that day and could set priorities. This helped organise the team and the care for people. A member of staff said, "There is good team work. We all help each other without asking." Team meetings were used in an effective way to concentrate on important themes when they arose. Staff were given the opportunity to raise concerns in these meetings, which were followed up my management.

At the last inspection we identified that we had not always been notified of significant events which meant we could not check that appropriate action had been taken when incidents occurred. We noted improvement in this area where notifications were made appropriately. For example, we received a notification recently when the lift was out of order. This meant that we could monitor the service and ensured that the manager implemented a plan to keep people safe.

People and relatives spoke of the service and the management with high regard. There had been some improvement made with people's support since our last inspection of the service. A relative said, "Improvements have been made. In the last month things are looking up."

People told us that the service had a positive culture. One person said, "It's a happy friendly place." Another person described the service as, "A place where you can ask and they are willing to help you." People and relatives told us that the manager and staff knew them well. The manager told us about the home's missions and values of providing care tailored to the need of people. When able to do so staff worked in line with this ethos during the day to day running of the service.

People were involved in the running of the home. We saw that during resident meetings people were asked for their suggestions on the menu and activities on offer at the service. People, relatives and staff felt that they could approach the management team with any problems they had. People said that the manager was approachable. Relatives told us that problems were acted on.

People and relatives told us that the acting manager was always on hand and visible in the home. The acting manager interacted well with people. People responded well to her and were pleased to see her. This reflected what we observed on the day of inspection.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect by staff.

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 requirements of the Mental Capacity Act 2005 were not always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always managed well or acted upon by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels had not been maintained and fell below the safe levels the provider had set.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	There was a lack of effective auditing in place. Improvements had not been made since the last inspection.

The enforcement action we took:

We served a Warning Notice.