RedHouse Care Limited

The RedHouse Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this home on 7 February 2017 following concerns which had been raised with us about the care and welfare of people at the home. The home provides accommodation and personal care for up to 36 older people, some of whom live with dementia. Accommodation is arranged over three floors with stair and lift access to all areas. At the time of our inspection 28 people lived at the home.

A registered manager was not in post at the home. 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. Although our register shows a registered manager was in post at this home, this person had not worked in the home since March 2016. A manager was employed in the service from March 2016 and applied to become the registered manager; however they had withdrawn this application and left the service in October 2016. A new manager had started at the home in November 2016 and was present at this inspection. They had applied to be the registered manager of the home.

We inspected this home in June 2016 and found the registered provider was not compliant with Regulation 9 (person centred care), Regulation 11 (need for consent) and Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (registration) Regulations 2009. Following this inspection the registered provider sent us an action plan stating they would be compliant with all the required regulations by August 2016. At this inspection we found the registered provider had failed to be compliant with all the required regulations.

Whilst people were supported by staff who understood how to identify signs of abuse and report these appropriately, we nevertheless found incidents of safeguarding were not always identified and investigated in a prompt manner to identify and apply any learning from these incidents in the home.

Whilst medicines were stored safely they were not always managed in a safe and effective manner. The registered provider had identified the need to change the system of administration of medicines.

The risks associated with people's care needs had been assessed and plans of care were informed by these however these records were not always up to date and available for staff.

There had been a very high turnover of staff in the home and processes were in place to check the suitability of staff to work with people. However not all staff had received training to ensure they had the skills to meet the needs of people and training records were not always up to date.

Health and social care professionals were involved in the care of people and care plans reflected this.

Staff ensured people who were able to consent to their care were involved in making decisions about their care. However, where people could not consent to their care staff were not always guided by proper assessed consideration of the Mental Capacity Act 2005.

People's nutritional needs were met in line with their preferences and people enjoyed the food they received. People enjoyed activities in the home.

Care plans in place for people reflected their identified needs and the risks associated with these, however these records had not always been updated. People and their relatives were involved in the planning of their care.

There was a lack of consistent and effective leadership and management in the home. Whilst staff felt supported by management there was a lack of structure and awareness of roles and responsibilities in the home. Records held in the home were not always clear, accurate or complete.

Systems and processes which the registered provider had in place at the home to monitor, assess and improve the quality of the service provided had not been effective in identifying the concerns we found at the home.

We have identified two repeat breaches and three further breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one repeated breach of the Care Quality Commission (Registration) Regulations 2009 during this inspection. You can see what action we have told the registered provider to take at the end of this report.

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.

Medicines were not always managed in a safe and effective manner.

Whilst systems were in place to support staff in recognising signs of abuse and they knew how to report these, some concerns identified in the service had not been investigated and reported to ensure people's safety and welfare.

Risk assessments had been completed to support staff in mitigating the risks associated with people's care, although further work was required to ensure these assessments were updated regularly.

Staff had been assessed during recruitment as to their suitability to work with people. There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always received training to enable them to meet the needs of people.

Where people could not consent to their care staff were not always guided by the Mental Capacity Act 2005.

People received nutritious food in line with their needs and preferences.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives said staff were caring and supportive of people's needs. Health and social care professionals said staff were caring and supportive of people needs.

We observed some kind, caring and thoughtful interactions with people, however we saw some people did not always have their dignity and privacy respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst staff understood how to provide care which was individualised to people's needs there was a lack of clear records to support them in this.

Activities were available for people and people responded warmly to the activities coordinator who knew people well.

Systems were in place to allow people to express any concerns they may have although feedback we received suggested communication of concerns was not always documented clearly and shared with management.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of consistent and effective leadership in the home.

Arrangements for the management of the home had led to inconsistent approaches in the leadership and expectations of staff, although staff felt supported by management.

The registered provider did not have effective systems and processes in place to assess, monitor and review risks associated with people's care and the quality of care in the home.

Care records were not always clear or accurate.

The RedHouse Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Two inspectors and an expert by experience completed this unannounced inspection on 7 February 2017. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. We reviewed information of concern we had received. This information helped us to identify and address potential areas of concern.

Some people who lived at the home were not able to talk with us about the care they received. We observed care and support being delivered by staff and their interactions with people in their rooms and communal areas of the home.

We spoke with 10 people who lived at the home, one relative and one visitor to gain their views of the home. We spoke with staff, including a management representative of the registered provider company, the nominated individual for the registered provider, the manager, the deputy manager and four members of care staff.

We looked at the care plans and associated records for five people and sampled two others. We looked at medicine administration records for 28 people. We asked to look at a range of records relating to the management of the service including records of complaints, accidents and incidents and quality assurance documents. We looked at six staff recruitment files and policies and procedures.

Following our visit we received feedback from three groups of health and social care professionals who

supported people who lived at the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the home and staff were available to help them. One person said, "I feel safe living here, I use a frame to help me around but I have never had any falls. I do take medication but the staff give that to me." Another told us, "They will help me with anything; I have nothing to worry about here." Staff felt people were safe in the home and that they understood how to meet the needs of people safely.

At our inspection in June 2016 we found the registered provider had not ensured medicines were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan stating they were compliant with this Regulation on 2 August 2016. At this inspection we found the registered provider had taken some steps to address this concern although there was further work required to achieve and maintain compliance with this regulation.

For medicines which were prescribed for people to take when required (PRN), protocols were not always in place to guide staff on when these medicines may be required, their use or how to monitor for the effectiveness of these medicines. For people who had been in the home for some time these protocols were in place; however, for two people who had recently been admitted to the home, some medicines were prescribed PRN to reduce anxiety or to control pain. There was no guidance in their medicines administration records (MAR) or care plans about the use of these medicines, or how and when they should be administered.

The risks associated with medicines people received had not always been identified and used to inform their plans of care. For example, for one person who required the administration of a blood thinning medicine, the risk associated with the administration of this medicine, which can include excessive bleeding and bruising, had not been identified and did not inform their plans of care. This meant this person may be at risk of not receiving the right care and treatment in the event of an injury or fall.

MAR records for another person identified the person may not be compliant with having their insulin medicine which was administered daily by the community nurses. We asked the deputy manager what staff should do if this medicine was declined. They told us community nurses would advise staff when this had happened and staff would observe the person. They said the community nurses would often return later to check the person. There was no information in the MAR or care records to identify this concern and how it should be managed. Whilst the management of this person's medicines was supported by the community nursing team, we were not assured staff had a good understanding of how to monitor this person and report appropriately to the community nursing team of other health care professionals if this was required.

We had received concerns that people did not always receive their medicines from staff who had received the appropriate training to complete this task. Whilst medicines were stored, ordered and monitored safely, we were not assured they were always administered by people who had received appropriate training and competency checks to complete this task. The manager told us only senior staff who were competent administered medicines however, training records showed four of five senior staff had not received up to

date training to complete this task.

We had received concerns about the timeliness of the administration of medicines in the home particularly in the morning. On the day of our inspection we saw a medicines administration round which should have been administered at 08:00am was not completed until 11:20am. We were not assured people received their medicines in a timely way as they had been prescribed.

The deputy manager told us they were aware the medicines round was taking a considerable time for senior staff to complete. They had been reviewing the medicines in the home and a new system of medicines administration from a different pharmacy supply was being implemented in the home in the week following our inspection. Staff were to receive training on this and this would allow two members of staff to be administering medicines at the same time and improve the timeliness of the administration of medicines. Following our inspection we received information which identified this system had been put in place and staff had received training on this.

The registered provider had failed to ensure people received their medicines in a way which ensured their safety and welfare. This was a repeat breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in June 2016 we made a recommendation that the registered provider reviewed information they held on record about safeguarding matters and to implement clear measurable action plans following any concerns which were raised in the home. At this inspection we found the registered provider had failed to take sufficient action to ensure staff were fully aware of their roles and responsibilities in the management of safeguarding matters in the home.

Information was displayed in the home to provide guidance for staff on what they should do if they suspected abuse and care staff were able to tell us signs of abuse and what they would do if they suspected this was happening, however only ten of 34 staff had received training on this. We had previously received information of concerns about the level of care being provided in the home and a serious incident which had occurred in the home which had not been reported to the local authority as a safeguarding matter. We had raised an alert with the local authority about these concerns.

We were not assured management staff had a good understanding of their roles and responsibilities with regard to the reporting and investigation of safeguarding matters in the home. At our inspection we asked the manager what actions had been taken to address the concerns which we had raised, and other matters which had been raised with the local authority safeguarding team about the standards of care provided at the home. We found investigations into concerns were not complete or lacked information on any learning actions identified for the home. We spoke with the local authority and the matters they had raised had not been fully addressed by the registered provider and were under continued review in the home. Following our inspection we raised further concerns with the local safeguarding authority with regard to the care of some people who had fallen or received injuries.

There was a lack of appropriate systems and processes in place to effectively investigate allegations or evidence of abuse in a timely manner. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in June 2016 we found the registered provider had not ensured risks associated with people's care had been fully assessed and plans developed to mitigate these risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered

provider sent us an action plan stating they would be compliant with this Regulation by 15 August 2016. At this inspection we found the registered provider had taken action to address this concern and there was no longer a breach of this part of the regulation, however further work was required to embed this practice in the home.

Most risks associated with people's care including falls, moving and handling and nutrition had been assessed and information relating to these risks and how to reduce them informed plans of care. However, further work was required in the home to ensure risk assessments and care records were updated regularly to reflect people's current needs and the risks associated with these. For example, for one person who had fallen and sustained a serious injury on 4 January 2017, their falls risk assessment and care plans were dated 14 October 2016. These had not been updated to reflect the current risks associated with the person's care. Staff were able to tell us how this person's care had been affected by this fall; however their risk assessment had not been updated.

For another person who was at risk of infections which may make them disorientated and increase their confusion, this risk did not inform their plans of care in place. Staff knew of this risk and how to support this person and reduce the chances of them getting an infection by encouraging them to drink plenty and monitoring them for any signs of infection; however risk assessments were not always in place and did not always inform plans of care for this person. Whilst risk assessments were not always up to date care staff had an understanding of how to identify risks associated with people's care and take action to reduce these risks.

We had received concerns that there were insufficient staff available to meet the needs of people in the home at times, particularly for people who required close supervision when they became anxious or distressed. At this inspection we found that whilst there were sufficient numbers of staff available in the home during our inspection, there were no people who required close supervision or support on this day. We asked the manager how they identified there were sufficient staff available to meet people's needs. They told us they did not need a dependency tool to identify the number of staff required to meet people's needs as they and the staff were aware of the needs of people in the home and that there were always sufficient staff to meet these needs. They told us that they and the deputy manager were always available to support people. If any person required additional support such as one to one supervision or closer monitoring then the manager told us they would, "Bring in more staff" and may need to employ a member of staff from an external agency.

Following our inspection the registered provider sent us information regarding a dependency tool which was available in the home at the time of our inspection, but was not in use. This identified the number of staff required to meet the needs of people as assessed on the computerised records system. The registered provider told us this tool had been in place at the time of the inspection and immediately following our inspection this was reviewed.

There had been a high turnover of staff in the service since our inspection in June 2016, including a change in the management staff of the home. The manager told us 90% of the staff who were working in the home, including the manager themselves and the deputy manager, had been employed within the past three months. Recruitment records for staff held information which included proof of identity, two references and an application form. Disclosure and Barring Service (DBS) checks were in place for staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed.

We discussed the recruitment of staff to management roles within the home with the registered provider as there had been a lack of consistency in this role over the previous twelve months. They told us they had reviewed their practices of recruitment to the role of managers within the home to ensure the suitability of all staff in management roles.

Requires Improvement

Is the service effective?

Our findings

People were offered choices and support to maintain their independence. Relatives had been involved in planning the care their loved ones received and worked with staff to ensure they received choice in line with their needs and preferences. People enjoyed the food choices available to them. Health and social care professionals felt staff requested their support appropriately.

At our inspection in June 2016 we found the registered provider had not ensured systems were in place to identify people had consented to the care they received. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan stating they would be compliant with this Regulation by 31 October 2016. At this inspection we found the registered provider had failed to take sufficient action to achieve and maintain compliance with this Regulation.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We observed staff offered people choices and allowed them to make decisions throughout the day such as what they ate, what clothes they wore and where they wanted to spend time during the day. Staff allowed time for people to make decisions. For example, one person was unable to choose what they wanted to eat for dinner when staff approached them in the morning. We saw staff took time to explain what choices were available and then left the person to make a decision, returning later to get their response. A member of staff told us, "They [person] sometimes just need a bit of time to decide so we leave them and then come back."

However, where people lacked the mental capacity to make decisions, the home was not always guided by the principles of the MCA. Whilst the manager and staff had some understanding of the processes required to ensure people consented to their care or decisions were made in their best interests, records showed these processes had not always been followed.

For example, for one person who had an independent mental capacity advocate (IMCA) to support them in making decisions which they were unable to make themselves, we saw neither they nor their IMCA had consented to the use of photographs. This consent form was signed by the manager of the home who had no legal authority to provide this consent. For another person whose care records stated, "advocate has given consent' for the use of photographs, the 'advocate' was a family member who did not have the legal authority to provide this consent.

We received feedback from two groups of health and social care professionals that staff did not always have a good awareness of the Mental Capacity Act 2005 (MCA) and had required support to ensure this informed their care planning and records. We found, whilst staff showed a good understanding of the need to gain

consent from people before they supported them, there was a lack of detailed understanding of the MCA. One member of staff told us "Most [people in the home] haven't got the mental capacity to make decisions." Another said, "I am not really sure about the legislation."

Care records we reviewed held sections which contained information on the person's mental health or cognition, although this section was not consistently held in records. Care plans we reviewed did not have a mental capacity assessment that asked whether the person could understand, weigh, retain and communicate the information related to any specific decision. For example for one person who required support with their dementia and cognitive needs a care plan in place stated, "Is able to make simple decisions." There was no information available to identify the decisions this person could make and how staff should support them if they were unable to make a decisions or who else they should involve.

We found the home was not meeting all the requirements of the Mental Capacity Act 2005. This was a repeat breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For twelve people who lived at the home an application had been made to the local authority with regard to them remaining at the home to receive all care. Some of these applications had been authorised and were identified in people's care records as having Deprivation of Liberty Safeguards in place. The manager had submitted a Deprivation of Liberty Safeguards application for two people who had recently been admitted to the home. This was reflected in their care records and the home were awaiting authorisation. We found the home was meeting the requirements of the Deprivation of Liberty Safeguards.

At our inspection in June 2016 we made a recommendation that the registered provider formalise a plan to prioritise training for staff to ensure they received this in a timely way once they started working at the home.

We had received concerns which identified staff did not have the appropriate training and skills to meet the needs of people. We asked the manager what training staff had received and how they ensured staff had the training and skills required to meet the needs of people. They told us there had been a very high turnover of staff in the home in the three months prior to our inspection and most of these staff had not received training identified as mandatory by the registered provider, however training was planned. They told us they would not have employed staff who they felt did not have the right skills and knowledge to meet people's needs and that they had requested staff provide certificates for the training they had completed in other care settings before they arrived at the home. Records showed these certificates had not been provided and there was no information to show staff had the skills and competencies required to meet the needs of people. However, we saw some staff had completed external qualifications such as National Vocational Qualifications (NVQ) and Care Diplomas before starting work at the home. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

There was a training matrix in place to identify the training staff had completed and the training they required. This showed the majority of staff had not received training since recruitment to the home to ensure they had the competencies and skills to meet the needs of people. For example, only eight of 34 members of staff had completed fire safety training, seven of 34 members of staff had completed first aid training and 13 of 34 staff had received training on the MCA. However information the registered provider sent us after our inspection showed this information was not an accurate record of training staff had

completed as some staff had completed other training which was not recorded.

We spoke with the registered provider about the apparent lack of training completed by their staff before they had started working in the home. We asked how they were assured all staff could meet the needs of people and ensure their safety and welfare. They told us they recognised that with a very large influx of new staff they had failed to ensure all staff received the programme of training they required. However a lack of records to identify the training staff had completed meant some of the information we had received was inaccurate. The registered provider took immediate action following our inspection to ensure staff had received training they identified as mandatory such as safeguarding of people, infection control, fire safety, manual handling and conflict management.

The registered provider required all staff to complete the Care Certificate. This certificate is an identified set of standards that care staff adhere to in their daily working life and gives people confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff had been enrolled on this programme and were required to complete this course within 12 weeks of commencing work at the home. The manager told us they had advised staff of the need to complete this and were able to monitor what units people had achieved but that there was a lot of work to do with this to ensure staff completed this training. Care staff told us they had started this training although there had been some difficulties in accessing the training on line.

The lack of appropriate training in place to ensure staff were able to meet the needs of people and ensure their safety and welfare was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A programme of supervisions was in place to provide staff with the opportunity to meet with their line manager and discuss any concerns they may have, however as most staff were very new to the home only one of these had been completed in the past two months.

At our inspection in June 2016 we found there was a lack of clear guidance and effective monitoring of the personalised support people required at mealtimes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan stating they would be compliant with this Regulation by 31 December 2016. At this inspection we found the registered provider had taken sufficient action to achieve compliance with this Regulation.

People received a wide variety of freshly homemade meals. They told us they enjoyed the food and were always offered choice if they did not wish to have the main meal of the day. Care plans reflected people's food preferences, likes and dislikes and people were encouraged to have a nutritious intake. The chef was aware of people's preferences and dietary needs. Mealtimes were a social occasion where people interacted with each other and staff were available if they were required to support people. Throughout the day we saw staff offered hot drinks for people and jugs of fluids were readily available in people's rooms and communal areas of the home.

Staff were allocated on a daily basis to monitor and maintain accurate records on the daily fluid and food intake of people who were at risk of malnutrition or required monitoring for their fluid intake. Whilst these records were well maintained further work was required to ensure they informed plans of care and identified ideal nutrition or fluid intake for people. People's weight was monitored and any discrepancies identified were reviewed and the appropriate support from health care professionals if this was required.

Health and social care professionals visited the home when they were required to support people's needs.

Care records reflected these visits and any instruction or guidance provided for staff.

Requires Improvement

Is the service caring?

Our findings

People said staff were caring and understood how to meet their needs although there were lots of new staff at the home. One person told us, "To me I think the staff are a rare breed, they really put themselves out for you. They are very good and caring and willing to have a natter with you." Another told us, "They [staff] are the best, there are lots of new ones but they are all lovely and really look after me." A third person told us, "I don't mind it here, the staff are nice, kind and respectful they look after me. They always ask me before they do anything." Health and social care professionals said staff appeared to be caring and compassionate as they supported people. Health and social care professionals said staff were, "Caring and well intentioned," and, "Kind and caring". Whilst we observed some very caring and considerate support for people, we also observed other interactions from staff which were not as caring.

Whilst most staff had not worked in the home for very long they knew how to interact with people and encourage them to remain independent. They addressed people by their preferred name and allowed people time to express their wishes and make choices in their daily lives. For example, one person chose not to join in activities which were taking place in a communal area of the home and staff patiently supported them to move from this area to a quieter area of the home. Another person chose to remain in their room during the day and this was respected. A hairdresser was visiting on the day of our inspection and people were encouraged by staff to use the service to increase their feeling of wellbeing. We saw one staff member encouraged a person to have a haircut and shave to feel fresh and comfortable and this person reacted warmly to staff and proceeded to have a haircut.

Staff had an understanding of the need to ensure people were treated with respect and dignity at all times. One person told us, "Staff always knock on my door when I am in my room and they help me when I need to go to the toilet and are very discreet." We saw whilst staff were supporting people with personal care in their rooms, their doors were closed. When one person exited the bathroom area of the home in a state of undress, staff were quick to support them in maintaining their privacy and dignity.

However, for one person who had difficulties in mobilising to the toilet independently and ensuring the door was closed when they were in a toilet area, we saw they were unable to reach a call bell. On two occasions they called out for two to three minutes for staff before they independently mobilised to the toilet area. They then sat on the toilet with the door open and in full view of people passing them. On the second occasion we closed this door for the person ensuring they were able to call for help before we did so. We asked the manager why staff did not respond to this person calling out for help to mobilise into the toilet and to ensure their dignity and privacy. They told us, "I have told staff to make sure the door is always closed for him." One member of staff responded to this person whilst they were in the toilet area and said, "What's this door doing open?" We were not assured this person was supported adequately to promote their privacy and dignity at all times.

For another person who was sitting in a communal dining area of the home at lunchtime they requested another meal and were told by a member of staff, "No, you don't need it." For a third person two members of staff walked into their room and spoke with a member of the inspection team without acknowledging the

person in the room, and on another occasion when we asked why a person did not have their glasses on to support their improved mobility and communication, a senior member of staff called out to staff in a communal area, "Why hasn't [person] got his glasses on, it's in his care plan!" This showed a lack of respect for the person and staff and could have been dealt with in a more professional and caring way to ensure the dignity and privacy of the person.

People were encouraged to personalise their rooms. However one person and their relative told us how they were concerned that one person wandered around the home into other people's rooms and often removed people's belongings from their rooms. We spoke with the manager about this and they told us this matter was being addressed with staff monitoring the person and some assisted technology (alarms) had been requested to alert staff to when this was happening.

People and their relatives were involved in providing information to inform their care plans although care records did not always clearly identify this. Care records showed staff interacted with people to understand their needs, views, preferences and dislikes. Relatives were involved in the planning of care for their loved ones.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives had been encouraged to express their views and be involved in making decisions about their care, however with significant changes in the leadership and staffing in the home this work required further embedding. Staff knew how to support people and support them to be as active and independent as possible whilst maintaining their safety and wellbeing. However there was a lack of personalised support available for some people as staff did not always have access to up to date records of people's needs.

At our inspection in June 2016 the registered provider had implemented a new computerised system of care records to provide a more comprehensive review of people's care and ensure plans of care were personalised. At this inspection we found this system had been implemented but required further embedding in the home to ensure it was used effectively by all staff to inform people's care.

Electronic care records showed people were assessed prior to their admission to the home and these assessments helped to inform their plans of care. People's preferences, their personal history and any specific mental or physical health needs or care needs they may have were documented. Risk assessments and plans of care for people's physical, emotional and health needs were completed and held in a computerised care record system. This allowed people's needs to be identified and rated as being high, medium or low and these ratings could then be used to inform the level of staff support people required.

We saw some staff, particularly those who had been in the home for a longer period of time, were able to provide some very individualised care and understood people's needs well. They told us how they supported other staff in understanding these needs too. For example, one member of staff was able to describe how they supported a person who could become agitated and concerned about their own wellbeing at times. They described how they could support this person and prevent their agitation escalating. Another member of staff was able to tell us how they supported a person who was cared for in bed most of the time and described how they supported this person to maintain their skin integrity and their nutrition. Staff shared their understanding of people's needs at handover times and were seen to seek support from each other to meet people's needs. The manager told us they planned to introduce keyworkers to the home. A keyworker would be a member of staff responsible for making sure a person's needs were being met, informing plans of care and liaising with family members about clothing and personal needs. This meant people and their relatives would be more involved in the planning and implementing of their care.

Whilst steps had been taken to ensure people's care was planned in line with their individual needs and preferences, staff did not always have access to accurate records of people's needs. We have addressed this in the well led section of this report.

An activities coordinator was employed in the home for five days per week and we saw people responded warmly and in keen anticipation of the activities they provided. One person told us, "We get to do lots here, whatever we want to join in with. Today we are playing fancy bingo to the music, great fun." Another told us,

"There is never a dull moment when [activities coordinator] is around, she brightens up the place." We saw people interacted well with the activities coordinator as they moved around the home.

There was a complaints policy in place at the home. The manager told us they had not received any complaints in the home since they had started. People and their relatives were aware of the policy and felt able to discuss any concerns they may have with staff. One person told us, "I know if I have any problems I can speak to any of the staff and they will help me. There is a new manager too." We had received one letter of complaint about the service which we forwarded to the registered provider who dealt with this promptly in line with their policy.

However, at our inspection we were made aware of a concern which had been identified by a visitor about a small injury a person had received. The manager and deputy manager told us they were not aware of this concern. The visitor told us they had reported the concern to a member of staff two weeks prior to our visit, but when they visited again they saw this concern had not been addressed. The manager and deputy manager reviewed this matter during our inspection and advised us that they would seek support from a healthcare professional to support this person, but that the person had come to no significant harm. It was unclear why this concern had not been identified as requiring attention from the manager and had not been reported. There were no records available to identify when this concern had been raised. The manager told us they would investigate the reasons this matter had not been reported and addressed.

Whilst a previous manager had held meetings with people and their relatives to promote good communication in the home and discuss any changes or concerns, there had been no meeting since our last inspection. The manager had in place a programme of meetings to be held with people, their relatives and staff. A meeting had been planned however had had to be postponed due to an infection outbreak in the home.

Inadequate

Is the service well-led?

Our findings

People and their relatives said they felt able to talk to staff and managers if they had any concerns and that these would be dealt with. They were aware there had been changes in the management of the home over the past 12 months and that this had led to some changes in the home. One person told us, "They [managers] are in the office up here to keep an eye on us all." A visitor told us how communication had not been very good in the home over recent months particularly during the infection outbreak which had occurred in the home preventing visitors coming to the home. Health and social care professionals we spoke with told us how recent changes in management had led to a lack of continuity in the home although this was improving. Staff told us they felt supported by managers to do their job effectively.

At our inspection in June 2016 we found the registered provider had not ensured records were accurate. Systems in place to assess quality and drive improvement in the service were ineffective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider sent us an action plan stating the actions being taken to complete this were on-going on 2 August 2016. At this inspection we found the registered provider had failed to take sufficient action to achieve and maintain compliance with this Regulation.

Although our register shows a registered manager was in post at this home, this person had not worked in the home since March 2016. A manager was employed in the service from March 2016 and applied to become the registered manager; however they had withdrawn this application and left the service in September 2016. A new manager had started at the home in November 2016 and was present at this inspection. They had applied to be the registered manager of the home. The registered provider told us they recognised the lack of consistency and good leadership at the home. The changing management styles and plans to improve the service had led to a high turnover of staff. There was a lack of clear and effective leadership in the home. The introduction of new ways of working in the home had led to confusion and lack of order in the organisation of the home and in particular in the keeping of records.

Care records lacked order and staff did not have access to clear, accurate and concise records which helped to guide them in the care people required. There were a variety of records held in the home in different places and there was no clear order to care records to ensure consistency for staff. Paper and electronic records in the service were not accessed by staff appropriately. For example, one member of care staff told us they had only looked at paper records of care plans and another told us, "We only enter our daily records on the computer. We don't have anything to do with the electronic care plans, that's for the managers." We asked another member of care staff if they had accessed the electronic care plans for people and they told us, "I'm not a very good person to ask. I have only been here a while." We saw care staff entered information onto the computer to inform daily care records, however staff did not access care plans.

Whilst most of the care records we looked at were individualised and contained information on people's needs, they were not always up to date and care staff had not always seen these. For example, for one person who had fallen in January 2017 and sustained a serious injury, their plans of care did not reflect this fall or any changes required in their care. For another person who had received a serious injury which

required them to attend hospital, care plans had not been updated to reflect their needs following this incident.

Care staff documented daily care records on the computerised care records system. These gave clear information on the support and care they had provided for people in line with their needs. However these daily records were not used to update plans of care for people and were not reviewed regularly by senior staff to ensure people were receiving the care they required in line with their preferences.

For care records which were held in people's rooms, we saw these were not always completed sufficiently and lacked detail about interventions of staff when they were with people. For example, for people who had food and fluid balance records kept, there was not always a target fluid intake noted for people. For people who were on hourly monitoring we saw care records did not always reflect the interventions staff completed. One member of staff told us they did visit people hourly in their rooms to observe them and ensure their safety however this was not always recorded.

Records regarding the application of prescribed creams for people had not been consistently completed. Whilst these medicines were prescribed on medicine administration records sheets there was no information to show these medicines had been administered as prescribed. Care staff were aware people required the use of these creams and told us how they completed this. However these records were not completed consistently.

Following our inspection the registered provider sent us information to say they had reviewed and updated all care records for people and ensured the computerised version of care records was used to inform all care provided. Staff had received training on this record keeping. They advised us they had identified that a large amount of information and records which we had requested to review during our inspection had been removed, archived and stored away without ensuring records had been sufficiently updated to inform people's plans of care and other records of actions taken in the service.

There were no audits of care plans or records completed in the service to ensure the registered provider was able to identify these concerns and address them.

Records held in the home regarding the training of staff were not complete and did not provide accurate information on the training of staff and any identified gaps in their needs

The lack of clear, accurate and complete records held in the service in respect of people and the care and treatment they received was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst the registered provider and manager had implemented a management structure in the home, they did not demonstrate a good understanding of their own roles and responsibilities in the home. During our inspection there was a lack of open and transparent communications in the home. The manager provided conflicting information about their awareness of concerns within the home and also of their understanding of their responsibilities in the home. They told us the concerns we had identified were because of a previous manager and the actions they had taken.
The manager told us the registered provider visited the home regularly to support them in their role and had encouraged them to drive improvements in the home. However, the registered provider and manager did not have a good understanding of what improvements were required in the home to ensure they were fully compliant with all the regulations. There were no clear actions identified through audits and review of the care provided in the home to identify any of the areas of concern we found during our inspection.

The manager told us they had reviewed the action plan which had been sent to us following our last inspection and did not believe the home was compliant with the required Regulations when they started at the home in November 2016. However they were unable to tell us how they had planned to address these concerns or how they had identified they remained a concern. We asked the manager and a management representative for the registered provider to show us any action plans, audits or review of the service which had been completed since our last inspection. They provided us with one health and safety audit of the home completed in March 2016 (prior to our last inspection of the home). The actions identified in this audit had not been confirmed as completed although the management representative of the registered provider company told us some of these actions had been completed. The manager identified another action plan which they told us had been completed with the local authority with regard to an incident in the home. This had not been completed and actions identified to fully inform further actions required in the home.

Incidents and accidents were not monitored and reviewed in the service to ensure people's safety and welfare. We identified two serious incidents which had resulted in people receiving injuries which required them to be admitted to hospital. The manager told us they did not know about these incidents. However, records showed these had been reported to the manager and that they or the deputy manager had advised staff on the actions to take to ensure the safety and welfare of people. We asked the manager why these incidents had not been reported to us or the local authority. The manager acknowledged that this should have been completed. They told us they had asked the deputy manager to do this and this had not been completed. The registered provider was not aware these incidents had not been reported to the local authority or to us.

The manager told us they were aware of incidents and accidents which occurred in the home only if they were reported directly to them. They told us all incidents and accidents were reported on the computer and were reviewed by the manager or deputy manager. They were unable to tell us of any recent incidents and accidents which had occurred in the home. Whilst there was a system in place to monitor and review incidents and accidents which happened in the home this was not being completed. There was no system in place to monitor for any patterns in incidents and accidents in the home. There were no records of investigations into incidents and accidents which occurred in the home to ensure learning was identified from these. Following our inspection we raised concerns with the local authority safeguarding team about the lack of reporting, monitoring and awareness of accidents and incidents of injury in the home. We also raised these issues with the provider.

Following our inspection we received information from the registered provider about the actions they had implemented to immediately rectify some of the concerns we had identified. However, there was a lack of system and processes in place to assess, monitor and improve the quality and safety of the services provided at the home. The registered provider had not ensured that systems to effectively assess, monitor and mitigate the risks associated with the care people received were in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had failed to ensure we were notified of serious incidents which occurred in the home. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

A planned programme of staff meetings was in place and staff told us they found the manager and deputy manager supportive of them in their roles. These meetings provided staff with the opportunity to discuss changes in the home and the new structure of staff was explained to staff to help them understand their roles.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to ensure we were notified of serious incidents which occurred in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not meeting all the requirements of the Mental Capacity ACT 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive their medicines in a way which ensured their safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a lack of appropriate systems and processes in place to effectively investigate allegations or evidence of abuse in a timely manner.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Staff had not always received appropriate training in place to ensure they were able to meet the needs of people and ensure their safety and welfare.

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 The registered provider had failed to ensure records in the home were clear, accurate and complete to inform the care people needed. The registered provider had failed to ensure systems were in place to effectively assess, monitor and mitigate the risks associated with peoples care.

The enforcement action we took:

We served a Warning Notice on the registered provider requiring them to be compliant with this Regulation by 8 May 2017.