Sanctuary Care Limited

Carlton Dene Residential Care Home

Inspection report

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Date of inspection visit:
10 January 2019
11 January 2019
15 January 2019

Date of publication:
03 June 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We had carried out a comprehensive inspection of this service on 31 July, and 1,3 and 10 August 2018. We issued three breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safety of the medicines management, the robustness of risk assessments for people who used the service and the quality of care planning. Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to meet the regulations.

After the inspection we continued to receive notifications from the provider about medicine errors that had occurred at the service. The relevant local authority safeguarding teams were also appropriately informed by the provider about these medicine errors. In December 2018 we attended a safeguarding meeting at the service in relation to medicine errors for one person who used the service.

This focussed inspection on 10,11 and 15 January 2019 was conducted to check whether the provider had taken suitable and timely action to address the areas identified for improvement at the previous inspection. The first day of the inspection was unannounced and the next two days were announced. This report only covers our findings in relation to this topic. You can read the report from our previous inspection, by selecting the 'all reports' link for Carlton Dene on our website at www.cqc.org.uk. We rated the service requires improvement at the previous inspection. At this inspection the service has also been rated requires improvement. This is the fourth consecutive rating of requires improvement for the service.

Carlton Dene is a 'care home' that provides personal care and accommodation for older adults. People living at the service require care and support as they are living with dementia and/or are frail due to chronic health difficulties and/or physical disabilities. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during the inspection. Carlton Dene can accommodate up to 42 people and 40 people were living at the service at the time of the inspection. The premises are purpose built and divided into four separate units. People are provided with a single bedroom with en-suite facilities and shared communal areas. The service provides permanent placements and respite care.

At the time of the inspection the registered manager was on maternity leave. A registered manager is a person who has registered with the CQC 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. The provider informed us they had appointed a peripatetic manager who will cover the rest of the registered manager's maternity leave. The service was being temporarily managed by the regional manager and the deputy manager.

At this inspection we found the provider had failed to ensure that people who used the service safely received their medicines.

Systems were in place to identify risks to people's safety and wellbeing. Risk assessments were in place and these were updated to reflect changes in people's needs and circumstances.

Improvements had been made to ensure people who used the service were provided with a safer physical environment. The premises were free from any offensive malodours and appropriate infection control procedures were followed to prevent cross infection.

People told us they felt safe living at the service and relatives expressed that their family members were safely cared for. The provider had liaised with local authority safeguarding teams and changed the way it sent safeguarding notifications, to ensure that information was appropriately received.

Staffing recruitment was undertaken in a detailed manner and there were sufficient staff deployed to safely meet people's needs.

Some improvements had been made with the quality of care planning, although additional work was needed. Staff had received training and had been supported by the regional development manager to increase their understanding of the importance of individual care plans and how these plans could be used to provide people who used the service with a better quality of life.

The provider had introduced new activities and opportunities for people who used the service to meet their social care needs and interests, which included visits from a befriending group. Due to prior difficulties at the service, the provider deferred its participation in Ladder to the Moon, to prioritise improvements within the service. The provider informed us that they will be restarting at the end of March 2019. Ladder to the Moon is an externally delivered project to enhance the quality of people's lives through the use of creativity, coaching, training and consultancy.

People and their representatives were provided with information about how to make a complaint. Records showed that complaints were taken seriously and responded to in a courteous way.

People's end of life wishes were recorded in their care plans and where applicable, clearly presented information was held in people's files in relation to their resuscitation status.

Although people and relatives spoke well of the deputy manager and the regional manager, the absence of a permanent manager had significantly impacted on the provider's ability to deliver a service that safely and appropriately met people's needs. The improvements since the previous inspection in the quality of the risk assessments and the care planning needed further development and the provider was unable to demonstrate sufficient progress with the improvement of the safety of medicines practices. The regional manager informed us of some challenges in the autumn of 2018, which resulted in the provider not being able to effectively carry out the proposed improvements detailed in their action plan.

Systems were in place to monitor accidents and incidents, and the views of people who used the service and their representatives were sought through surveys and consultations.

We have found a repeated breach in relation to the provider's failure to ensure that medicines were managed safely within the service.

We also found a breach of regulations in terms of governance of the service.

You can see what action we asked the provider to take at the back of the full version of the 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.

The provider had not satisfactorily improved the management of medicines to ensure people consistently received their medicines safely.

Improvement had been achieved with the standard of risk assessments and the accompanying care plans to mitigate identified risks to people's safety, however we found some minor discrepancies.

The premises were safely maintained and suitable practices were in place to prevent cross infection.

There were sufficient staff on duty, who were correctly recruited.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some improvements had been achieved with the development of individual care plans to identify and address people's needs and wishes. However, more work was needed to ensure that all care plans were satisfactorily written and reflected the views of people and their representatives.

People were provided with opportunities to meet members of the local community and enjoy social activities. However, the service had not attained sufficient progress with its participation in a project designed to improve the quality of people's lives and experiences.

Complaints were managed by the provider in a polite and responsive manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although people and relatives liked the management team in place at the time of the inspection, the provider had not ensured

that the service benefitted from a sustained period of stable management.

The provider had not managed to improve the safety of the medicine service and continued to not provide a high quality of care and support for people who used the service.

Staff reported they felt well supported by the management team and actions had been taken to ensure they understood their roles and responsibilities.

Systems were in place to record accidents and incidents, so that any trends could be identified and addressed.

Carlton Dene Residential Care Home

Detailed findings

Background to this inspection

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

This focussed inspection was conducted over three days. The first day was unannounced and the subsequent days were announced. The inspection team comprised two adult social care inspectors and a medicines inspector on the first day and two adult social care inspectors on the second day. One adult social care inspector returned to the service on the third day to conclude the inspection and give feedback to the provider. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service responsive and is the service well-led?

Prior to the inspection we spoke with the contracts monitoring officer from the local authority, who was conducting weekly quality monitoring visits. We reviewed the information we held about the service, which included statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required by law to send us. The provider also sent us a specific action plan in relation to the actions they were taking to improve the safety of medicines management at the service. We had requested this action plan after we had attended a safeguarding meeting held at the service in December 2018.

Some people who used the service were not able to tell us their views about living at Carlton Dene so 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 about the quality of their care and support. During the inspection we spoke with five people who used the service and one relative. We additionally spoke with four care staff, two senior care staff, the activities coordinator, the chef, the regional maintenance person, the deputy manager, the clinical development manager and the regional manager. We

met two pastoral care visitors from a local church, who told us about how they engaged with people who wished to participate in the activities they offered. Following the inspection visit we spoke by telephone with the relatives of four people.

We looked at a range of documents which included five care and support plans and the accompanying risk assessments, the complaints log, policies and procedures, 10 medicine administration records (MARs), accidents and incidents records, minutes of meetings for people who used the service, their representatives and staff, and the provider's own quality monitoring reports and audits.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we had found that medicines were not always safely administered to people who used the service and the governance systems to support safe medicine processes were not robust. We had found that there had been medicine errors, including medicine administration records (MARs) not being completed correctly, medicines being administered at incorrect times and missing medicines. For example, we had found two people did not have protocols in place for their 'when required' medicines. When staff had administered these medicines, they had not always been correctly recorded on the medicine administration records (MARs) as outlined in the provider's policy. The issues we had found constituted a breach of Regulations.

At this inspection we found the provider had made some improvements, however there were still gaps in the medicine administration records (MARs) and medicine errors were being regularly identified through the auditing system. We saw that a temporary system was in place to audit medicines daily. At the time of the inspection audits were being carried out by the clinical development manager. However, during the period the service was managed by an interim manager the audits had been discontinued and the number of errors had increased. This identified gaps in the MARs and medicine administration errors. Although the new system was robust, errors and gaps continued to be identified. For example, we noted that the provider had identified 14 gaps on the MARs on 8 January 2019. We found that the system had not been imbedded into the service and therefore may not be sustainable.

We looked at medicine administration records (MARs) and the care and support plans for 10 people. Some people were prescribed medicines on a 'when required' basis. There was guidance in place to advise staff when and how to give these medicines, which was kept with the MARs. There was guidance in place for the use of over the counter medicines for the treatment of minor illnesses. However, we found on one occasion a person who was already prescribed paracetamol four times a day, was given an additional dose of paracetamol to treat a minor illness. The intervals between the two doses were not long enough, causing a risk of side effects to the person. This had not been identified by management in the daily audits of MARs.

We found medicines reconciliation were not always completed as recommended by NICE. This is the National Institute for Clinical Excellence guidance to promote the safe and effective use of medicines in care homes by advising on processes for prescribing, handling and administering medicines. For example, we found that on one occasion the provider had failed to verify an accurate list of a person's current medicines in a timely way. When the provider had followed this up, they identified one of the medicines was a controlled drug. During this time the provider had not complied with the Misuse of Drugs (Safe Custody) Regulations 1973.

People were prescribed creams and ointments to be applied to their body and staff completed topical medicines administration records (TMARs). Some people were given their medicines disguised in food or drink without their knowledge, which is known as covert administration. This was carried out in their best interests following assessment under the Mental Capacity Act 2005 (MCA) and a documented best interests review.

During our inspection we observed medicines being administered by care staff. However, for one person we saw medicines were not administered safely. The person retained the tablet in their mouth and did not swallow the medicine. Staff told us that the person did not like taking medicines in the morning. Management informed us that they would contact the GP to get further guidance on administering medicines to this person. We saw evidence that people's medicines had been periodically reviewed by their GP and people with mental health conditions had their medicines reviewed more frequently.

This constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection we had found that although there were risk assessments in place within people's care plans, there had been some issues in relation to how staff had acted to mitigate identified risks. For example, the risk assessment for one person who used the service had identified that additional falls prevention documentation and an action plan needed to be completed but this had not been undertaken. The issues we had found constituted a breach of Regulations.

At this inspection we had found that the provider had made improvements. The risk assessments we looked at within the five care plans we selected contained appropriate information to demonstrate that individual risks to people's safety and wellbeing were recognised and suitable actions were taken to minimise the occurrence of the identified risks.

One person who used the service was identified to be at risk of choking. Staff had requested a GP review and the person was referred to a speech and language therapist (SALT). The professional guidance from the SALT was used by staff to promote the delivery of safer care and support. We noted that where a person had experienced recent falls, the falls prevention risk assessment and the accompanying care plan had been updated to reflect this. The person was referred to an occupational therapist (OT) for an assessment of their needs. The person's relative informed us they were pleased with how the staff had responded to the deterioration of their family member's mobility.

Another person's care plan contained a risk assessment as they had been found smoking cigarettes in areas within the premises not designated for smoking. The accompanying care plan confirmed how staff supported the person to maintain their safety and the safety of others.

We saw examples of where the clinical risk assessments had been suitably altered to reflect changes in people's needs and circumstances. The provider used Waterlow, which is an assessment tool that gives an estimated risk for the development of a pressure ulcer in each person. The Waterlow risk assessments we looked at demonstrated that staff had improved their understanding of the necessity to consider any significant changes in people's age, continence status, mobility and other factors each month when they completed these assessments.

The eating and drinking monthly risk assessments used the Malnutrition Universal Screening Tool (MUST), which is a screening tool to identify adults who are malnourished, at risk of malnutrition or obese. The tool includes management guidelines which can be used to develop a care plan. A risk assessment for a person's eating and drinking showed a progressive decline in the person's ability to maintain a satisfactory level of nutrition. We noted that staff had discussed their concerns with the person's GP and a referral had been made to the applicable external health care team. Another person's care plan showed that an error was made in December 2018 by a member of staff in the scoring of the eating and drinking risk assessment. We noted that the staff member who completed the assessment in January 2019 detected the incorrect entry and recorded a correct score for their own assessment. This person's individual folder showed that

guidelines from a dietitian had been incorporated into the service's own risk assessment and accompanying care plan, and the professional guidance sheet was also readily available for staff to refer to.

We found some minor discrepancies in the risk assessments we looked at, which we discussed with the management team during the inspection. The provider confirmed that supporting staff to accurately complete and thoroughly review risk assessments was an ongoing exercise.

At the previous inspection we had found that people who used the service had valid Personal Emergency Evacuation Plans (PEEPs) in place. A PEEP is a bespoke 'escape plan' for people who may need help and assistance to leave the building in the event of an emergency evacuation. At this inspection we noted that staff continued to complete these documents in a satisfactory manner.

Improvements had been made since the previous inspection in relation to the safety of the premises, for example practices in the kitchenettes on each unit. At this inspection we noted that staff consistently ensured knives, including carving knives, were kept in locked cupboards. Opened food items were labelled with the date of opening and the date to be disposed of by, and we did not find any expired items.

At the previous inspection we found that the premises were clean, however we noted some issues in relation to malodour and infection control practices. For example, we had observed that two communal toilets had an unpleasant odour, and the call bells and light cords in the communal bathrooms and toilets were discoloured. At this inspection we found these issues and other concerns we had detected had been satisfactorily resolved. There were no malodours and all but two of the light cords had been replaced. A new call bell system had been installed. The regional manager stated that the two remaining light cords we spotted were an oversight and would be replaced without delay.

At the previous inspection we had noted a need for the redecoration and removal of broken and unused equipment throughout the premises. We had also observed some cupboards and doors which were required to be kept locked had ill-fitted, broken or missing locks. At this inspection we noted the premises had been decluttered, storage areas had been organised and all doors that required locking were locked. Improvements had been made to the laundry room and there was now a clear system in place to ensure that people's clothes and other laundry was safely and hygienically managed.

At the previous inspection we had identified that mops were not being air dried but stored in buckets with or without water. At this inspection we saw mops being air dried. The regional manager told us she was currently the lead for infection control and a senior care worker was due to attend specific training in March 2019 so they could take on the role of 'infection control champion'. The plan was for the deputy manager or another staff member to also attend this training, to ensure the responsibilities of this role were covered in the absence of the designated champion. We saw that monthly infection control audits were carried out, which identified concerns and actions to be taken.

At the previous inspection we had noted that the care home had a cockroach problem, which was being dealt with by pest control. At this inspection we found a dead cockroach floating in a toilet bowl. We looked at the pest control record of visits and found the provider had clear evidence that an external pest control agency had been dealing with this problem. During the inspection the regional manager confirmed that the pest control officer had been informed of our observation and called out for a visit.

People who used the service told us they felt safe living at the care home and the relatives we spoke with expressed positive views in relation to how the service ensured the safety of their family member. Where applicable, relatives told us their family members received one to one care and support in line with people's

assessed needs. One relative said they felt reassured their family member would be sensitively supported if they attempted to abscond from the premises and staff understood how to keep their family member safe. Other comments from relatives included, "I think they (staff) are kind and caring people" and "The carers look after [him/her] very well. I visit every day, [he/she] is happy, I'm happy."

Staff had received safeguarding training and had received information about how to whistle blow within the company and externally to other organisations. Whistle blowing is when a worker reports suspected wrongdoing at work. The provider informed the local authority of any safeguarding concerns and notified the Care Quality Commission. Prior to the inspection, we were advised by the local authority that there were possible omissions by the provider in relation to the reporting of safeguarding concerns when people who used the service had unexplained bruising. We immediately contacted the regional manager to seek written information and reviewed this matter during the inspection. The regional manager explained to us that different reporting systems were used to contact local authorities, in accordance with the individual instructions of the local authorities. The provider was following the process given to them by a local authority but the local authority experienced issues with their collation of information. The provider informed us they had discussed a new way of working to support the local authority. We did not find records to indicate that the provider had failed to meet its legal responsibility to report safeguarding concerns.

We discussed the safeguarding notifications with the regional manager during the inspection and looked at the actions the provider had implemented to keep people safe. One of the relatives we spoke with told us they thought the staff did their best to support people when one person who used the service became agitated towards another person.

At the previous inspection we had noted that the staffing levels had been increased following medicine errors, to enable senor care workers to focus on their medicine administration responsibilities. At this inspection we saw that the staffing levels had been maintained. People who used the service and relatives told us they thought there were sufficient staff deployed and the staff we spoke with confirmed their satisfaction in relation to staffing levels. The regional manager informed us there were no imminent plans to adjust the current arrangements.

At the previous inspection we had found that safe processes had been followed to safely recruit staff with suitable experience and skills to support people who used the service. At this inspection we checked five different staff files, including the files for any staff appointed at the service since our last inspection visit. We found one discrepancy in relation to a reference for a member of staff. We asked the regional manager to obtain further details about the actions taken by the provider's human resources team to ensure that rigorous recruitment practices were adhered to. The regional manager provided suitable evidence on the third day of the inspection to demonstrate that correct processes were followed to ensure a prospective employee was suitable for employment at the service.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we had found several discrepancies in people's care plans that identified areas for improvement. For example, staff had not completed an 'individual profile' for one person who used the service although they had lived at the service for 18 months. This document is similar in design to a 'life history' and seeks information about people's childhood and young adulthood, as well as their later years, likes and dislikes, to enable staff to provide individual care and support to meet people's needs. Other care plans had contained inaccurate information about people's family support networks or had not been updated to demonstrate how staff should deliver care to respond to a person's changing needs. The issues we had found constituted a breach of Regulations.

At this inspection we found the provider had commenced the process of improving the quality of the care plans, although ongoing work was needed to ensure that people who used the service had individual care plans that directly reflected their needs, preferences and wishes, and could be effectively used to enhance the quality of their lives. The regional manager and the regional development manager demonstrated that staff had received training about how to develop individual and meaningful care plans. This included discussions with staff in relation to their understanding of how care plans should be developed to demonstrate consultation with people who used the service and/or their representatives, people's assessed needs including assessments by external professionals, goal setting, action planning and risk management. We noted that a professional from the local authority contracts monitoring team had worked closely with the management and staff team since the previous inspection to improve the quality of the care plans.

At the previous inspection we had noted that a person who was originally admitted to the service for respite care which was changed to a permanent placement did not have a full care plan, although it was a few weeks since their placement had been confirmed as being permanent. The provider had rectified this during the inspection. At this inspection we looked at a care plan for a person admitted for respite care, who was due to return to their own home. Although the person arrived at the service at a busy time of the year and were expected to soon leave, we noted that staff had developed the person's care plan within the first few days. The care plan demonstrated that staff had clearly spoken with the person, and their relative where applicable, about their current needs and circumstances. There was also helpful information recorded by a member of staff about the person's earlier life and family composition, which provided staff with a relevant understanding of issues that might have impacted on the person's physical health and emotional needs.

Following the inspection visit, we spoke by telephone with the relative of a person who's care plan we had looked at during the inspection. We found that the information in the person's care plan about their earlier background and accomplishments, family history and the impact of their health care condition on the quality of their life had been suitably recorded by the staff who developed the person's care plan.

At the previous inspection we had spoken with people about the activities they engaged in at the service, and had met with the activities coordinator to discuss the activities programme. We had noted that the service had developed beneficial links with local community organisations, for example students from nearby schools visited regularly to support people who used the service to take part in activities and other

volunteers came each year from a National Citizens Service project for young people. There were also scheduled visits from organisations that provided therapeutic activities, for example music and movement sessions.

On the first day of this inspection we met two volunteers from a local church who provided a weekly activities session at the care home, which included playing games and singing songs. On the final day we met a group of people who used the service returning to the premises, having visited the church centre as part of a weekly invitation from the volunteers. We observed that people were smiling and enthusiastic, and appeared to have enjoyed an opportunity to venture outside of the service for an activity.

During the inspection we noted that the deputy manager had considerable experience in promoting people to engage in fulfilling activities within the care home sector and through his own extensive experience as a volunteer with community organisations. The regional manager informed us that the deputy was working with staff to improve the quality of social stimulation provided to people who used the service. We were informed that since the previous inspection the service had introduced a new befriending scheme operated by members of the Church of Scotland located in Westminster and visits from an Irish chaplain. There were also opportunities for people who used the service to interact with a visiting dog on some weekends.

A relative commented to us that they did not always observe that their family member received a service that was tailored to their needs when they were being provided with one to one care by a care worker. We had also observed this during the inspection.

At the previous inspection we had observed people who used the service and staff to join together to open up a box of theatrical props from Ladder to the Moon, which is an organisation that supports care services to improve the quality of care they deliver and provides creative projects to enhance relationships between people who use services and staff. At this inspection we were informed by the regional manager that it had been necessary to suspend the Ladder to the Moon project due to internal difficulties experienced at the service. We were advised that the project had now recommenced and the activities coordinator had attended a workshop in the first week of January 2019.

People who used the service and their representatives were provided with information about how to make a complaint. At the previous inspection a person who used the service had told us they were not happy with aspects of their care and support, and they consented for us to pass on their concerns to the regional manager. At this inspection the person told us the provider had taken considerate action to address their complaint. One relative commented, "I spoke with [deputy manager] when I had concerns about [family member] and he was very helpful and reassuring." Another relative told us they were planning to raise a concern about an item that needed to be removed and replaced in their family member's bedroom. The relative felt the management team would respond in a professional manner. The complaints log showed that any complaints were investigated and complainants received a polite and helpful reply.

At the previous inspection we had found that one Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) form had been signed by a hospital doctor at a time that the person who used the service was an inpatient. We had discussed this finding with the regional manager and she had agreed that this should be followed up so that the person's current needs and wishes could be reviewed by their GP. At this inspection we noted this had been addressed. The care plans we looked at contained information about people's wishes, for example if they wished to see a religious minister in their final weeks or days, and whether staff needed to be aware of any instructions to be adhered to if they passed away at the service. At the time of the inspection none of the people who used the service were receiving end of life care.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection people who used the service and their relatives had not had sufficient time to get to know some members of the management team. At this inspection we found that people and their representatives were familiar with the deputy manager and the regional manager. Relatives told us they were satisfied with how the service was managed. People and relatives told us they found the management team "approachable" and "friendly."

We noted that there had been changes in the management team since the previous inspection. The registered manager had taken maternity leave in early 2018 and the appointment of an interim manager following our previous inspection was short-lived. The deputy manager at the time of the previous inspection had left the organisation and the new deputy manager had commenced in his role in September 2018, having had some prior knowledge of the service in a visiting advisory role from another local care home operated by the provider. The regional manager had ceased her daily presence at the service after the induction of the former interim manager, although she had continued to provide senior management support. The regional manager informed us that there was a non- productive period since the previous inspection and the service had not made the level of progress and improvement anticipated by the provider.

At this inspection we found that although the required improvements to the quality of the risk assessments and the care planning had begun, there were still ongoing improvements to be achieved to ensure that new ways of working were properly implemented and maintained. Improvements had been achieved to provide people with a safe environment to live in. The provider had not made sufficient improvements with the management of medicines to ensure that people who used the service received a consistently safe service.

The ongoing issues of concern in relation to the safe management of medicines, the period of unstable management at the service and the provider's failure to have effective systems in place to improve the service and promote a high quality of care had resulted in Carlton Dene being rated as requires improvement for the fourth time in a row.

This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we were informed by the regional manager that a full-time peripatetic manager would be in post by March 2019, who will cover the rest of the registered manager's leave. Although there had been various changes in management at the service and a brief period of management that was acknowledged to have been problematic and unsettling for staff, we received positive comments from staff about the quality of leadership at the time of the inspection. Staff told us they felt supported by the management team and they liked the 'hands-on' approach of the deputy manager who worked with them on the units to demonstrate more effective ways to support people who used the service.

We noted that staff had been visited by managers from head office and a meeting was held to discuss the

provider's concerns about the quality of care and support at the service. The regional manager showed us a letter that was due to be sent to all members of staff which clearly outlined the provider's expected standards of performance and conduct. We were informed that this letter was devised to ensure that all members of staff were reminded of their key responsibilities so that everyone could work cohesively towards improving the quality of the service, and was not intended to suggest that there were general issues of concern about the approach of staff. Records showed that the regional manager and the deputy manager were holding weekly meetings with staff, which included time for staff to ask their own questions about any care issues.

The provider's recording and analysis of accidents, incidents and other events demonstrated that learning took place to promote safer care for people who used the service. We were shown the results of the Carlton Dene resident satisfaction survey, which showed a high level of satisfaction by the respondents. The regional manager confirmed that people who used the service and their relatives had been consulted and provided with further information about the planned move to a newly built care home, which was due to be ready in the spring of 2020.

We saw that the provider was working towards the improvement objectives identified by the local contracts monitoring team, although progress was at a slower pace than expected. The provider appropriately sent notifications to the Care Quality Commission without delay, and the current rating of the service was prominently displayed at the premises and on the provider's website.

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 17 HSCA RA Regulations 2014 Good governance The provider had not taken effective action to improve the quality of the service. 17(1)(2)(a)

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed at the service. 12(20(g)

The enforcement action we took:

We issued a warning notice.