

ONH (Herts) Limited

The Orchard Nursing 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?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection was carried out on 8 August 2017 and was unannounced. At their last inspection on 18 April 2017, they were found to not be meeting the standards we inspected. At this inspection we found that they had continued to not meet all the standards.

The Orchard Nursing Home provides accommodation for up to 63 older people, including people living with dementia. At the time of the inspection there were 40 people living there.

The service had a manager who was not registered with the Care Quality Commission (CQC). 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 and associated Regulations about how the service is run. The manager told us that the provider was recruiting for a permanent registered manager.

People's medicines were not always managed safely and staff needed further development in relation to fire safety procedures. There were also mixed views about staffing. Staff were recruited safely, however, references needed to be consistently verified. There were audits completed but these did not identify all of the issues found on inspection. The service has been rated requires improvement and been in breach of regulations for 20 months.

People's care needs were not always met in a person centred way and care plans were not always reflective of people's current needs. People felt that the activities needed further improvement.

People were supported by staff who knew how to recognise and report concerns about their safety. Individual risks were assessed and accidents were reviewed and the kitchen was adhering to safe working practice. People were supported by trained staff and staff told us that they felt more supported.

People were supported to eat and drink and there was regular access to health and social care professionals. This included the appropriate referrals.

People were treated with dignity and respect. They told us that staff were kind. People and their relatives had their involvement in care planning improved and confidentiality was maintained.

People's feedback was sought and complaints were responded to.

There was a clearer management structure in place and people and staff told us they had seen some improvements. Systems in place had improved communication in the home.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two

consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

People's medicines were not always managed safely.

Staff needed further development in relation to fire safety procedures. Individual risks were assessed and accidents were reviewed and the kitchen was adhering to safe working practice.

Staff were recruited safely. However, there were mixed views about staffing

People were supported by staff who knew how to recognise and report concerns about their safety.

Is the service effective?

Good ●

The service was effective.

People were supported by trained staff.

Staff told us that they felt more supported.

People were supported to eat and drink.

There was regular access to health and social care professionals.

Is the service caring?

Good ●

The service was caring.

People were treated with dignity and respect.

Staff were kind.

Involvement in care planning had been improved.

Confidentiality was maintained.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People felt that the activities needed further improvement.

People's care needs were not always met in a person centred way and care plan were not always reflective of people's current needs.

People's feedback was sought and complaints were responded to.

Is the service well-led?

Inadequate ●

The service was not consistently well led.

There were audits completed but these did not identify all of the issues found on inspection. We found that there remained issues and the service had been rated requires improvement for 20 months.

There was a clearer management structure in place.

People and staff told us they had seen some improvements.

Systems in place had improved communication in the home□

The Orchard Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. At their last inspection they were found to not be meeting the standards we inspected. We reviewed the action plan that they sent us detailing how they would address the shortfalls.

The inspection was unannounced and carried out by three inspectors.

During the inspection we spoke with eight people who used the service, two relatives, twelve staff members, the regional manager, a supporting manager and the interim manager. We received information from service commissioners and health and social care professionals. We viewed information relating to seven people's care and support. We also reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Is the service safe?

Our findings

When we inspected the service on 18 April 2017 we found that people's medicines were not managed safely, safe food hygiene practice was not consistently followed and people were not always protected from harm. At this inspection we found there had been improvements in relation to reporting unexplained injuries and the food hygiene practice, however, people's medicines were not always managed safely.

There were not suitable arrangements for the safe storage and management of people's medicines. People were supported to take their medicines by staff that were properly trained. Nursing staff had access to guidance about how to support people with their medicines. We observed nurses administering medicines to people and they followed safe practice. Medication Administration Records (MAR) were completed once staff observed the person taking their medicine. We checked a random sample of boxed medicines and found that the stock did not always agree with the records maintained. For example, there were either too many or too few indicating poor record keeping or missed or duplicated doses. We also found that variable dose medicines for example take one or two tablets, was not always recorded clearly to inform what dose a person had received. Daily reconciliation of medicines did not always pick up a discrepancy in quantities and a recent audit had not identified the issues found on the day of inspection.

We also found that a person had been prescribed a course of antibiotics by their GP. The nurse on duty administered the first dose of the antibiotic and they handed over to the night nurse at the end of their shift. The night nurse pointed out that the person had an allergy to this antibiotic which was not observed or known by the nurse on duty during the day. The night nurse stopped the antibiotic and contacted the out of hours GP for advice. They were advised to monitor the person who by 3.45am developed a rash over their chest and their knees and legs were burning. The nurse called for advice again and were told to wait for the person's GP the next day. When we checked the medicines records (MAR's) we found that the MAR chart had been printed by the pharmacy and where the allergies should have been listed it said, "Check the care plan". In front of the MAR chart people had an identification chart with their picture, date of birth and the allergies they had. The allergy to this antibiotic was listed on the identification chart but this had not been identified at the time of receiving the prescription or administering the medicines.

One person also told us that there had been two occasions in recent weeks when they were offered someone else's medicines. The person explained to staff that they were not their and the staff members challenged them, asking if they were refusing their medicines. Since the incidents a formal complaint was being investigated by the manager and the deputy manager brought a staff member to apologise to the person. However, this meant that staff were not following the safe practice in this instance by reading the person's name and checking the photo attached to medicines records. This increased the risk of people who were not able to speak up receiving the correct medicines.

Staff we spoke with were not clear on how to evacuate people in case of a fire. They told us if they discovered a fire they would raise the alarm and go downstairs to inform others on how many people needed hoisting out of bed. We saw that there had been a recent fire drill but work needed to be carried out to ensure all staff had attended a drill and had the appropriate knowledge how to respond in the event of a

fire. People had personal evacuation plans in place which did instruct staff to hoist people and start with a horizontal evacuation and then vertical, however we felt that in case of a fire, especially on the top floor, this was not achievable. There were at least four people on the top floor in adjacent rooms who needed hoisting. We also found that actions in the fire risk assessment had not been signed as completed; we asked the management team to ensure all of these actions had been completed. However, we did note that one action to install an evacuation chair had been carried out.

Risks to people's well-being were identified and we saw staff working in a way to mitigate these risks. For example they used individual slings for people who needed hoisting to ensure that the risk of cross contamination was mitigated. They also used pressure relieving equipment for people who were at risk of developing pressure ulcers. We checked a number of pressure relieving mattresses and found that they were all at the correct setting.

We found that although staff were knowledgeable of the risks and how to mitigate these people's care plans were not always descriptive of the risk management plans. For example, where people were identified at risk of choking staff had management plans in place to prevent the risks, however there were no plans available to detail what action they needed to take if people showed signs of choking.

People who were identified as having behaviour which may have challenged on occasion had no plans in place to ensure that all the staff had a consistent approach to manage this. One staff member told us how they were offering personal care to a person who had behaviour which challenged at times. The approach and support provided differed across the team. Staff recorded on an behavioural chart when people had these behaviours and then that they managed to deliver the care needed, however there were no details about how they managed this and what method they used which was effective. We found that on two occasions a person suffered bruises and a skin tear during personal care and staff involved specialist mental health team in their care, however they had not collectively agreed a plan to follow and help ensure this person was safe.

Therefore, due to the shortfalls in knowledge in relation to fire safety, risk management for behaviour that may challenge and the issues identified in relation to medicines, this was a continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection views on staffing were mixed. Some people told us that they needed to wait for long periods of time to use the toilet. At this inspection we found that views remained mixed from people and staff. One person told us, "The days where things are better are more frequent but it's not every day." The went on to tell us that since our last inspection on one floor an extra member of staff had been added three days a week to support with bathing and other tasks. They told us, "This has made a difference."

Some staff told us that staffing levels were ok when they were fully staffed. They told us that in staff sickness it made it hard. Particularly during the night if the 1st floor was short of a member of staff, the nurse from the ground floor needed to support the remaining staff member. All staff told us this put pressure on the team and meant for delays in care for people. One staff member said, "I can only say that at times is very hard. We have more people for hoisting and one staff should assist with breakfast out of the four. The nurse has their own things to do so it is very busy especially in the morning." Another staff member said, "We work very hard to keep people safe but there is no time to sit and chat with people, which would be nice." A third staff member said, "Once or twice a month we are short on night shift by either a nurse or healthcare assistant. This means that people may need to wait for their care and support." One staff member told us that a person on 15 minute observations fell as they were short staffed and were unable to monitor them at that frequency. We raised this with the manager to ensure this was investigated and the appropriate action taken

if this did occur due to staff shortage. However we found that on the date of this incident the staff were not short staffed and the person fell in between monitoring checks. Staff also told us they thought they needed more staff around certain times in the day when it was busy like the mornings to enable them to spend more time with people.

We discussed this with the management team who told us that they did all they could to cover shifts but last minute staff sickness it was not always possible. Staff told us that this was less frequent than it had been previously. We noted that the home was calmer than it had been on previous inspections and call bells were answered promptly. We did not observe anyone waiting for a long period of time for support. However some people told us that there were days where they could wait for up to 20 minutes to use of get off of the toilet. We discussed the dependency assessments and staff deployment with the management team who told us that these would be reviewed. They also told us that the management team spend time on the floors monitoring where staffing would need to be amended. Even though staff told us they were busy, we saw that staff consistently supported people in a calm, patient and unrushed way. However, staffing needed to be kept under review by the management team to ensure that they were able to meet people's needs safely and in a person centred way.

Safe and effective recruitment practices were followed to make sure that all staff were of good character and suitable for the roles they performed at the service. We checked the recruitment records of two staff and reviewed profiles for agency staff working in the home and found that these included the necessary information. Recruitment files included all of the required documentation was in place including two written references and criminal record checks. However, we noted that references had not been validated with the referee, to ensure that they were genuine and that there was no further information to add. This was an area that required improvement.

People told us that they felt safe living at The Orchard Nursing Home. One person told us, "I do feel safe here, I didn't want to come into a home but my family live down here. They (staff) are very nice here and I like my room." People were supported by staff who knew how to recognise and respond to concerns of abuse. One staff member said, "I do report anything I find concerning. During personal care we check peoples` skin and report sores, redness and bruising to the nurses. I can find numbers for [local authorities] displayed in the lift and noticeboards." Another staff member said, "The manager encourages us to report any incidents immediately." Some staff did not know where to find the numbers for external agencies to report to; we asked the management team to raise awareness in this area. We saw that there was information displayed around the home to remind people, staff and visitors how to raise concerns. When we last inspected the service we found that unexplained bruises were not always recorded and reported appropriately. At this inspection we found staff were informing the management team of any issues and the manager was taking the appropriate action to investigate or report concerns.

The kitchen was clean and hygienic. We reviewed areas that had previously had not been cleaned effectively and found that they were clear from food debris. Safe practice was being followed in regards to food storage and there was an up to date record of cleaning and checks being completed.

Accidents and incidents were being monitored to ensure that all remedial action had been taken. For example, to add the need for more frequent supervision, crash mats on the floor next to people's beds or a referral to a health professional.

Is the service effective?

Our findings

People were supported by staff who were trained and supported. One person told us, "I get on very well with the staff, they are very good." A relative told us, "The staff are wonderful." Staff told us they received an induction training and they shadowed a more experienced staff member when they started working at the home until they learned people's routine. One staff member told us that when they started they read some people's care plans, however they found it more useful to learn about people when they were shadowing and constantly working on one unit.

One staff member said, "I don't remember having training as such when I started but I shadowed. I did read care plans at the beginning but I found that working on the same unit helped me more to learn about people." They continued, "I received the Care Certificate booklets in April, but when you work [number] nights each week I don't really know when they [managers] are expecting me to do it." Another staff member told us, "We are offered training and I really enjoy it. It is a shame I could not attend Dementia training because we were short staffed." However we saw that there were additional training sessions scheduled to help ensure everyone was able to attend and complete training required.

Staff told us that they felt that the support they received from managers could have been better. For example they told us they received supervisions on occasion however they felt these were not as effective because they were carried out by different managers working for the provider but not in the home. However staff also told us that they appreciated the current management team and they felt more supported then before. One staff member said, "In a long time this is the best management team we had. They know what they are doing and the support is better. However we still need to improve."

We reviewed the training spreadsheet and found that some recent training had taken place but some was still awaiting completion. We saw that staff had received training in relation to moving and handling, safeguarding, infection control, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), first aid and dementia care.

People had their consent sought and the staff worked in accordance with the principles of the mental capacity act. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found that they were. However we found that this was not consistent and all elements were not assessed on one of the units in the two of the plans we viewed. For example, people had capacity assessments in relation to the use of bedrails, but not always for the need of personal care or covert medicines. Best interest practice was taking place but it was

not always documented. The manager told us that they were auditing the plans to ensure that the appropriate assessments were put into place retrospectively. We saw that the manager held a log of all DoLS submitted, their progress and any conditions that needed to be met for those authorised.

People told us, and our observations confirmed that staff explained what was happening and obtained their consent before they provided day to day care and support. We noted that 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions and, where appropriate, their family members as well.

People told us that they were provided with a good choice of food and that they were supported to choose where they wanted to eat their meals. One person said, "The food is good quality, I'm quite happy with it." Another person told us, "The food has improved in recent times." A further person told us, "The food is very good indeed." However some people gave some less positive feedback. One person told us, "We have 'target' mealtimes such as breakfast, lunch and tea. Nothing is offered between tea at 5pm until breakfast at 8am apart from some stale biscuits." Another person told us, "The menu has just changed again. I am diabetic and I manage this myself by making a choice of what is on the menu. There is no specific food for people who lived with diabetes, even the yoghurt is high in sugar." We raised these points with the management team who assured us that diabetic foods and evening snacks were available. We asked that they review this and ensure that staff were offering these foods. However, this was an area that required improvement to ensure that people's dietary needs were consistently adhered to.

We observed breakfast and lunch served in a communal dining room and we noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence as much as possible. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble. Tables were nicely laid with cloths and condiments were on the tables to support people to be independent.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that these assessments were kept under review and amended in response to any changes in people's needs. People had their weight monitored regularly and staff used a tool to identify if people were at risk of not eating or drinking enough. Food and fluid charts were completed however we found that these were not always a true reflection of what people had. For example we found that staff recorded on a fluid chart for a person had a total of 3080ml in one day. When we asked the nurse they told us that it was not possible for the person to drink so much in 24 hour and that they were aware of recording issues which they were addressing with care staff. We found that it was part of the nurse's role to review intake charts each day to identify any concerns. As a result care records showed specialists such as GP's, dietician and speech and language therapist were involved in people's care when they were identified losing weight or having swallowing difficulties.

People had access to health and social care professionals. We noted from care plans that appropriate referrals were made to health and social care specialists as needed and there were regular visits to the home from dietitians, opticians and chiropodists.

Is the service caring?

Our findings

People told us that the staff were kind, caring and helpful. One person told us, "I can't say enough good about the staff, they are so helpful." Another person told us, "There are some carers who do with damned good job." Another person who used the service told us, "The staff are generally kind and caring, there are many new staff and it takes a while to get used to them. There are less agency staff now than there was."

Staff respected people's dignity and made sure that they supported people in the way they wished whilst encouraging them to remain as independent as possible. During our inspection we noted that people's bedroom doors were close whilst they received personal care and door signs were deployed to indicate whether people wished to be disturbed or not. We saw staff promoting people's dignity and privacy by knocking on people's doors and waiting before entering people's rooms. People were offered choices. For example, at breakfast time we heard staff ask people where they would like to sit, who they would like to sit with and whether they wanted to wear an apron or not.

People received care from staff in a kind, caring and respectful manner. Staff were friendly, courteous and smiling when approaching people. We observed sensitive and kind interactions between staff and people who used the service. The way people related to staff demonstrated good relationships between them based on respect and trust. Staff addressed people using their preferred names and it was clear that staff knew people well.

People looked presentable and well groomed. People's hair looked clean and combed. People had their manicure done and their nails were painted. However we did see two people who needed their fingernails to be cleaned.

Although some care plans were written in first person there was little evidence on one unit of how people were involved in their care. We saw relative's involvement throughout the care plan and detailed communication logs with families. Staff always informed family members about any changes in people's condition in accordance with the consent in their plans.

The environment throughout the home was warm and welcoming. People's individual bedrooms were personalised with many items that had been brought in from their home such as cushions and pictures.

People's care records were stored in a lockable office in order to maintain the dignity and confidentiality of people who used the service. We noted that the office was closed when staff were not using it.

Is the service responsive?

Our findings

At our last inspection we found that people's hobbies, interests and life histories had not been taken into account for the planning of activities and engagement in the home. At this inspection we found that work had been done to develop the activities and people had engagement booklets introduced. These included people's life histories and hobbies. There was also a record of one to one activities they had participated in. Following the last inspection and the arrival of the new manager there had been a meeting with the activities team to discuss plans and how to improve the provision of activities. The manager ensured staff were clear on their roles and how to move things forward.

However, during the course of the inspection we did not see any activity or social engagement taking place in the home. The manager told us people had an exercise session before lunch on one of the units. A person who used the service told us, "We need things to keep the boredom at bay." Another person who used the service, said, "It's easy to put the TV on, and then leave it on. It gets tedious after a while." Another person told us, "There is not much to do here. I would like to go on more good outings to places. I would like more interesting entertainment or places to go. I would like more good singers to come in, most that do come are not that great." A third person said, "Activities have slipped. We used to have three exercise sessions a week when I first came here, there have been none for ages now. I have played a couple of games of chess with the activities person but not a lot else." We did note that one person was enjoying gardening on the balcony and others were doing puzzles in their bedrooms. Another person told us that they had friend visit weekly to play bridge. They also told us, "The manager organised a cream tea and Primm's afternoon in the garden for Wimbledon, it was very nicely done."

People's care needs were met but not always met in a person centred way and care plans were not always reflective of people's current needs. When we arrived at 6.30am, people were clean and comfortable in their beds. Throughout the day we saw people receive support when requested. However one person told us, "I'd like to see more time being given to walking. No one offers to walk with me. It would be nice, maybe just twice a week on a regular basis. I would like to feel I'm doing something to get better instead of just sitting here in a blasted chair. When I asked staff they say they are too busy. Someone to sit and talk with me to help me with my speech would be beneficial too." We asked a staff member about this person's needs, they told us that they regularly offered the opportunity to walk with the person however, this was refused. The person's care plan in relation to mobility did not include any reference that staff should offer to help the person mobilise and care records did not show where the offer had been made and the person had refused.

We also found that staff did not always follow preferences in people's care plans. We identified two people who preferred female care staff. However, we found that male staff had been delivering care. We noted that these people were resistant to personal care and staff had not linked that having male staff may be a contributing factor. Plans were not clear in regards to one of these people and how to support them during a process that they found difficult. We discussed this with the management team and asked that they review it. This was an area that required improvement.

Therefore due to people's feedback about activities and the issues in relation to person centred care, this

was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's care plans contained clear information. However in some cases, we found that the information was not always reflective of people's needs. For example, when needing support for behaviour that challenged. We did see that there was a 'Resident of the Day' system in place where each plan was getting reviewed. We also saw that there was a care summary in people's rooms to guide staff to support people in a way they needed. People and their relatives had been involved in developing people's care plans. People's care plans were reviewed regularly to help ensure they continued to meet people's needs. We saw that people's relatives were invited to attend monthly review meetings where appropriate.

At our last inspection we found that the management team were not always aware of the concerns and complaints people had and people and their relatives felt they were not listened to. At this inspection we found complaints were recorded and reported to the manager for further investigation. The manager where needed investigated and they responded to the complaints detailing the actions they were taking to prevent reoccurrence. The complaints policy was made available to people, relatives and visitors to the service and this also signposted people to external organisations for support. However, one person who used the service told us, "I have never raised a formal complaint and would not know how to." The person went on to tell us that they thought they would probably tell the manager if they had any concerns but said they were not sure who was the manager of the home was at this time. We passed this on to the management team.

Meetings for people, relatives and staff were becoming more frequent. However, they were not very well attended at present. The dates for the upcoming meetings were displayed around the home. For those meetings held we saw that had covered recruitment and staffing, menus, information about the manager's coffee morning so people could drop in, the introduction of a resident's council and different services they were looking into, such as a visiting Barber. We saw that relatives raised concerns about staffing and the future of the home and the management had responded. There was a suggestion for a garden party. We were told by people that this had taken place.

Surveys to obtain people's views were in the process of being sent out, responses were not yet available.

Is the service well-led?

Our findings

When we inspected the service on 18 April 2017 we found that systems in place to monitor the quality of the service were not sufficiently embedded to demonstrate their effectiveness and identify shortfalls. We rated well led as inadequate due to the continued shortfalls in relation to the management and governance in the home. We met with the provider following the inspection to ask them to provide assurances about how they would make and sustain the required improvements. In addition they provided us with a monthly action plan detailing their progress and any issues found. At this inspection we found there had been improvements to the management of the home and the systems in place to monitor the service were more effective. However there were some areas that still needed further development.

There were a range of management audits undertaken routinely including a kitchen audit, medicines audit, mealtime monitoring, housekeeping audits, infection control audits and a health and safety maintenance audit. We reviewed these audits and noted where issues had been identified such as staff members not following hand hygiene protocols and catheter leg bags not being dated action plans were developed to address these issues. However, we noted that the audits were not always comprehensive and did not identify some issues we had found out this inspection. For example shortfalls in record-keeping and medicine management.

We found that some records like turning charts and half hour or hourly observation charts were completed either retrospectively or before the care happened. For example, in the morning at 6.45am when we checked the turning charts and the observation charts for people, we found that some half hour and hourly observations were not completed since 1am when the others were already completed for 7am. We discussed this with staff on duty and one staff member told us, "Sometimes we have the time to complete the charts as we do the care, but sometimes we don't have time and we do it at the end of the shift." Another staff member said, "Staff know they need to be completing charts when they deliver the care. I just don't know why they are doing this." This was an area that required improvement to ensure that recording was completed accurately.

The manager in post was a temporary manager employed by the provider and was not registered with the Commission. We were told that the provider was recruiting for a permanent registered manager. They were brought into the home to help drive improvement. They were supported by a management team from the provider and were in the home regularly to provide an additional overview. In addition, there were two deputy managers in post who worked seven days a week to ensure management support was available every day. However, it is a condition of their registration requirements that the service has a registered manager.

Staff were positive about the current in house management arrangements, however they told us that the constant management changes were unsettling for them. One staff member said, "It is hard for staff because every manager who comes has their own style so it's hard to adapt." We saw that there had been team meetings, including in the evening to accommodate night staff, where the manager had shared information with staff, discussed actions and changes needed and what the standards expected were.

Staff told us they were not always confident in raising issues in staff meetings or their supervisions. One staff member told us, "I would not be confident to raise issues in staff meetings. I think it reflects on me in a bad way." Staff had also shared with us at this inspection, previous inspections and through other contact with us, that they felt intimidated by some members of the senior management team. We had raised this previously but staff told us that this had not improved. Feedback in relation to staffing had been negative at all inspections. Even though we found on the day of inspection that needs were met, people and staff told us that staffing continued to impact on people's care needs being met in a timely way on a regular basis.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. However, we were not informed when shifts ran under their usual staffing levels.

At this inspection the service has been rated requires improvement and has not been complying with regulations for 20 months. Therefore due to the continued concerns, this was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were daily meetings where members of the management team and other key team members from across the home met to discuss any issues, staffing, health concerns and accidents. These were carried out consistently and notes showed that information was being shared both ways. Actions taken to address the issues found were also documented, for example securing staff cover and engaging with the chef manager about the menu discrepancy. There was also a manager daily report that the nurse on each shift was to complete and share with the manager daily. We found that this had improved communication and the manager was aware of issues, complaints and unexplained bruises within 24 hours. This meant they were able to carry out the required actions promptly. For example, such as raising a safeguarding alert or contacting family members. A member of the management team was also completing walk rounds. During these they looked at staff working practice, including infection control and moving and handling, monitoring people's care and the environment.

The manager involved the staff in a project implemented by NHS-specialist dental care. They had a dental nurse visiting and training staff in how to deliver effective oral care to people living in the home. The nurse told us they felt staff were interested and followed the advice they were giving. The nurse told us they felt as a result the staff were more aware of the importance of maintaining good oral hygiene for people.

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 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	People did not always received person centred care or sufficient activities to meet their needs.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	The provider did not ensure people's safety was maintained in relation to management of medicines, fire safety procedures and plans for behaviour that challenged.
Treatment of disease, disorder or injury	

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
Diagnostic and screening procedures	The service had not made sufficient or consistent improvement in the past 20 months.
Treatment of disease, disorder or injury	

The enforcement action we took:

We issued a warning notice instructing the service of when they must make the required improvements.