Scotia Health Care Limited

Scotia Heights

Inspection report

Scotia Road
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14 March 2017

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 13 and 14 March 2017.

Scotia Heights provides accommodation and nursing care for up to 60 people. On the days of our inspection 55 people were living in the home. The provider offers a service for people who have a neurology disorder and brain acquired injury.

The home had a registered manager who was present for the inspection. 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.

Prior to our inspection we received information from a person who wanted their identity to be protected. They alleged there were insufficient staffing levels provided to meet people's needs.

At this inspection we found that one unit was not sufficiently staffed to ensure people's needs were met. The provider's recruitment process entailed safety checks to ensure the suitability of staff. The risk of harm for some people was not always managed effectively. People were at risk of not receiving the appropriate support to take their prescribed medicines. People told us they felt safe living in the home. Staff were aware of their responsibility of sharing concerns of potential abuse with the registered manager to protect people from the risk of further harm.

People were cared for by skilled staff who were supported in their role by the management team. People confirmed they were able to make their own decisions. Staff were aware of the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards. People were supported by staff to eat and drink sufficient amounts and were assisted to access healthcare services when needed.

People received different care and attention depending on what unit they lived on. People were encouraged and supported to be involved in planning their care to ensure they received a service the way they liked. People's right to privacy and dignity was respected by staff. Practices and access to appropriate equipment helped people to maintain their independence.

People's involvement in their care assessment ensured their care preference was met. Some people were supported by staff to pursue their interests and hobbies. People were supported by staff to maintain contact with people important to them. People knew how and who to share their concerns with.

The provider's governance was not entirely effective to ensure people's needs were always met. People were encouraged to have a say in how the home was run. The home was managed by the registered manager who was supported in their role by the operation manager.

You can see what action we told 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 consistently safe.

People were not always supported by sufficient numbers of staff to meet their care needs. People cannot be assured they will receive their medicines as prescribed. The risk of harm to some people was managed effectively. People were protected from the risk of potential abuse because staff knew how to safeguard them.

Is the service effective?

Good

The service was effective.

People were cared for by skilled staff who were supported in their role. People's confirmed they were able to make their own decisions. Staff were aware of principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards. People were supported by staff to eat and drink sufficient amounts and were assisted to access healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The quality of care and support provided to people varied in relation to what unit they lived on. People were encouraged to be involved in planning their care to ensure their preferences were met. People's right to privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always have access to activities that supported their personal interests or hobbies. People were involved in their care assessment to ensure they received care and support the way they preferred. People knew how to share their concerns but these were not always managed in a way they liked.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's governance was not effective to assess, monitor or to drive improvements. People were encouraged through meetings to have a say in how the home was run. The home was run by the registered manager who was skilled and supported in their role by the operation manager.

Scotia Heights

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 inspection took place on 13 and 14 March 2017 and was unannounced. The inspection team comprised of two inspectors, an Expert by Experience and a Specialist Advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. A Specialist Advisor is a person who is specialised in a care subject area. The Specialist Advisor used at this inspection was a specialist in nursing care.

As part of our inspection we spoke with the local authority to collate information they held about the home. We also looked at information we held about the provider to see if we had received any concerns or compliments about the home. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

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.

During the inspection we spoke with ten people who used the service, five staff members, three visitors, a visiting care professional, the registered manager and the operations manager. We looked at six care plans and a risk assessments, medication administration records and records relating to quality audits.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we received an allegation that there were not enough staff on duty to meet people's needs. At this inspection we received mixed comments about the staffing levels. One person who used the service said there were not enough staff to support them. They said they needed to be repositioned whilst in bed every two hours. They informed us they had been repositioned at 10.30am and at 3pm they still had not been repositioned. Further discussions with the person confirmed their skin had not been affected by the infrequent repositioning. However, they said, "If I am not turned my back really hurts." They told us this happened frequently even though they had shared their concerns with the registered manager. We heard a staff member say, "I have rang all the units but there isn't anyone available to help us turn you." We observed the person became tearful as the staff member told them this. We asked the staff member why the person had not been repositioned since 10.30am. They said, "There simply isn't enough staff on duty." We spoke with a different person who said, "There isn't enough staff on duty, so I can't have a cigarette when I want one." This person needed to be supported by staff when they had a cigarette to ensure their safety.

On the same unit we sat in the lounge with three people, two of which required medical equipment to assist them with their breathing. There were no staff present in the lounge for 45 minutes until an operation manager approached us. During this period we kept close observation in view of getting staff to assist a person. This person had a tracheostomy to help them to breath. We heard several gurgling noises which could indicate the person needed assistance with their tracheostomy care. We shared our concerns with the operation manager who said, "Staff had disappeared because the inspector was present." They assured us this would be addressed. Within a few minutes of sharing our concerns with the operation manager a staff member entered the room. Within minutes the staff member acknowledged this person required assistance with their tracheostomy care and removed them from the lounge. This was of concern because this person was left without support and care for 45 minutes. The lack of support with their tracheostomy care placed them at risk of discomfort and could compromise their breathing. Another staff member entered the lounge and sat with people. They said they didn't have the time to sit with people and they were only doing so because the inspector was there. They continued to say, "When we get people up in the morning, we wash and dress them and put them in front of the television all day." They continued to say, "I feel sorry for these people but we don't have the time to sit or do anything with them." They told us that due to not having enough staff on duty people sometimes missed out on having a drink. After our inspection the provider informed us there were sufficient staffing levels provided but recognised there was a lack of staff organisation. This had an impact on the care and support provided to people.

We did receive some positive comments from some people who lived on a different unit. One person said, "Staffing levels is generally OK, sometimes there is not enough during the day, but I don't usually have to wait too long for support." Another person said, "When I press the buzzer [nurse call] alarm the staff come quickly." They told us they required two staff members to assist them with their mobility and staff were always available to support them. We spoke with a visitor who said, "There is always enough staff on duty."

People could be confident that staff were suitable to work in the home. The registered manager said all staff members have a Disclosure Barring Service [DBS] check before they start to work at the home. All the staff

we spoke with confirmed they had a DBS check. DBS assists the provider to make suitable recruitment choices. Staff also confirmed references were requested as part of the provider's recruitment process. These safety checks assisted the provider in selecting the right staff to work in the home.

At our previous inspection in August 2015, we found improvements were required to support people who needed assistance with their breathing who had a tracheostomy. A tracheostomy is an artificial airway that is used to help people to breathe. At this inspection we found that the provider had introduced systems to improve tracheostomy care. However, staff were not using these systems effectively and people remained at risk of harm. For example, one of two records we looked at relating to tracheostomy care informed staff about the importance of checking the equipment at least twice a day. The records showed from the 5 March 2017 to the day of the inspection, checks had not been carried out at this frequency. This placed the person's health at risk. Staff and the registered manager were unable to confirm whether these checks had been carried out and staff had failed to record this. The care record informed staff about the appropriate pressure range for the tracheostomy tube cuff [part of the tracheostomy equipment]. However, we found that the recommended pressure for the cuff had been exceeded. The over inflation of the cuff can cause trachea [windpipe] wall damage. Care records informed staff that the inner tube should be changed every four hours. However, records showed there were gaps of five and eight hours before the inner tube was changed. This increased the risk of the tube becoming blocked which could compromise the person's breathing. The registered manager was unable to say why these discrepancies had not been identified and acted on.

One person told us about their health condition and the support they required. The person's care record provided staff with information about their health condition and the importance of monitoring their blood pressure. Failure to monitor the person's blood pressure could be life threatening. However, we found that not all staff who supported this person was aware of this, which compromised the person's health.

Prior to our inspection we received concerns from a person who alleged their relative had left the home without support and this placed them at risk of harm. They were unhappy with how their relative's risk was managed. At this inspection we found the registered manager had taken the appropriate action to safeguard this person from the risk of harm. For example, a behaviour monitoring programme was put in place. This looked at triggers and suggested ways of managing their behaviour. Diversion techniques were also used. This is where staff takes the person away from what is upsetting them. The staff we spoke with were aware of the behaviour monitoring programme and how to support the person. The managers had liaised with the Clinical Commissioning Group to obtain additional funding for one to one support which was agreed. This meant the person had been provided with additional support to ensure their safety.

One person told us they required treatment for pressure sores. They said, "The staff turn me regularly in bed, apply my cream and dressings." We looked at their care record which provided staff with information about how to support the person to maintain healthy skin. Staff confirmed they had access to these records that supported their understanding about equipment required to prevent pressure sores and to promote healthy skin.

We looked at how the provider managed accidents. The registered manager said accidents were recorded and we saw this. This enabled them to monitor and identify trends. This gave the provider the opportunity to take action to reduce the risk of a recurrence. For example, ensure people were provided with the appropriate equipment to enable them to mobilise safely and reduce the risk of falls.

People were not always supported to take their prescribed medicines. For example, a medication administration record [MAR] contained information about the person's prescribed medicines. Staff had

signed the MAR to show when medicines had been administered. However, we saw that one medicine prescribed for the treatment of allergies had been signed by staff to indicate it had been given to the person. We observed that the medicine was still in the blister pack. The nurse in charge was unable to explain why this medicine had not been given to the person.

One person had been prescribed a medicine for the treatment of an infection. We saw that 200ml had been prescribed. The MAR showed that 150mls had been administered and the course had been completed. The registered manager was unable to explain why the person had not been given the remaining 50mls. They said their audit had identified this discrepancy and assured us this would be investigated. Another person had been prescribed treatment for dry and sensitive mouth to be used three times a day. This treatment supplements natural saliva. The MAR showed the person did not receive this treatment as directed by the prescriber. The nurse in charge and the registered manager were unable to explain why this medicine had not been administered.

We observed that medicines stored in the refrigerator were not maintained at the temperature identified on the packet. For example, the recommended storage for medicines identified on the medicine package was between two and eight degree Celsius. Temperature monitoring records showed temperatures reached 11 degrees Celsius. There was no evidence of what action staff or the registered manager had taken to resolve this. This placed people at risk of receiving medicines that were unsuitable for use because the chemical properties may have been affected by high temperatures.

We spoke with two care staff in who worked in different units. They told us they supported people with their prescribed medicines. However, both staff confirmed they had not received any training to deem them competent to manage medicines. However, we did find any evidence that these staff members had made any errors. We shared information with the registered manager about unskilled staff assisting people with their medicines. The registered manager said they were unaware of these practices. They assured us this would be reviewed to ensure medicines were managed by only trained staff.

The MAR showed some people had been prescribed 'when required' medicines. These medicines are prescribed to be given only when required. For example, medicines prescribed for the treatment of pain. Staff had access to support plans that told them how to manage these medicines safely.

One person said, "As soon as I moved into the home, staff sorted out my prescribed medicines." Another person told us, "Staff give me my medicines when I need them." A different person said, "I have never had any missed dosage of medicines." We spoke with another person who told us about their health conditions which was controlled by medicines. They confirmed that staff ensured they received their treatment as prescribed.

People told us they felt safe living in the home. One person said, "The staff listen to me and that makes me feel safe." Another person told us having access to a nurse call alarm made them feel safe. Staff had a good understanding about potential abuse and how to recognise this. All the staff we spoke with confirmed they would share any concerns of abuse or poor care practices with the registered manager. Staff were also aware of other external agencies they could share concerns of abuse with to protect people from the risk of further harm. We spoke with a visitor who said, "[Person] is safe here because they are well looked after." Discussions with the registered manager confirmed they were aware of when to share concerns of abuse to the local authority to safeguard people.

Good

Is the service effective?

Our findings

The people we spoke with said they felt staff had the skills to care and support them. However, we identified that two staff who supported people with their prescribed medicines had not received medication training. This placed people at potential risk of not receiving their medicines safely. One staff member told us they were provided with an induction when they started to work at the home. They told us their induction entailed training. For example, safeguarding, first aid and moving and handling. This gave them the skills to care for people safely. We spoke with another staff member who said, "My induction taught me things I didn't know." They continued to say, "I was unaware of people's special dietary needs but I learnt all this in my induction." The registered manager told us that staff had access to routine training and staff confirmed this. One staff member told us they had access to specialist training. For example, epilepsy and diabetes. This provided them with the skills to care for people with these specific health conditions.

People were supported by staff who had access to regular one to one [supervision] sessions. One staff member said that during these sessions their training needs were identified. They told us they also received feedback about their work performance and where improvements were needed to meet people's care and support needs. We spoke with another staff member who said, "During my supervision we have discussions about my work performance and I am able to ask for support when needed."

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.

People were encouraged by staff to make their own decisions. One person told us they were able to make their own decision about their meals and the clothes they wore. Another person's bed was fitted with safety rails to prevent them falling out of bed. The person had consented to the use of these rails and this was recorded in their care record. A different person was provided with a harness on their wheelchair to ensure their safety. They had consented to this being fitted to their wheelchair. All the staff we spoke with had a good understanding of MCA and had adapted the principles within their work practice. Staff told us they always obtained people's consent before they assisted them with their care and support needs. A staff member told us about a person who was unable to talk but had a communication board that enabled them to make a decision.

People who lacked capacity could be assured they would receive the appropriate care and treatment. This is because where necessary a best interest decision had been made on their behalf. Records showed a best interest decision had been made on behalf of a person relating to the management of their finances. We spoke with a care professional who said they were visiting the home to carry out a best interest decision. They told us that person was present in the meeting and they had an independent mental capacity advocate [IMCA] to support them. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about their care and

treatment options.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). One person had recently moved into the home. The registered manager said arrangements were in place to carry out a mental capacity assessment. This was because an emergency DoLS application had been submitted to the local authority to deprive the person of their liberty. This was to ensure they received the appropriate care and treatment. The mental capacity assessment would determine whether the person had capacity to make a decision and whether the DoLS application was appropriate. Discussions with one person confirmed their awareness of why a DoLS was put in place for them. They said, "I can go out but a staff member needs to be with me." They told us they were still able to access local amenities and do their own shopping.

People had a choice of meals and were supported by staff to eat and drink sufficient amounts. One person said, "They ask you every day what you want to eat." They told us they preferred healthier options and confirmed the cook always provided this for them. People told us they had access to drinks at all times. We observed a staff member assist a person with their meal. This was carried out at the person's pace whilst they engaged in conversation with them. The staff member frequently asked if they wanted a drink. Another staff member observed a person was struggling to swallow their food. They offered the person an alternative meal that would be easier for them to chew and swallow.

The staff we spoke with had a good understanding about suitable meals for the individual. For example, one staff member told us about a person who had difficulty swallowing and required fork 'mashable' foods and pureed meat. We looked at a care record relating to another person that informed staff of the risk of the person not eating sufficient amounts. The person was required to be weighed regularly. The records we looked at confirmed the person was weighed as stated in their care record. Staff told us if they had concerns about how much a person ate and drank a chart would be put in place to monitor this. Where necessary concerns would be shared with the GP and the person would be supported to access a dietician or a speech and language therapist. These professionals would provide the person and staff with advice and support about suitable meals.

People were supported by staff to access relevant healthcare services when needed. One person told us about their healthcare needs and said they had access to a physiotherapist, occupational therapist and a GP when needed. A different person said, "If you need a doctor the staff will call one for you." A staff member told us that people had good access to healthcare services. They said, "If a person's health deteriorates we tell the nurse and they will contact the relevant healthcare professional." We looked at one care plan that provided evidence that the person had access to a variety of healthcare services. Another care record showed the person had recently moved into the home. Action had been taken to register them with a GP. We spoke with a visitor who said, "[Person] has good access to healthcare services when needed. They informed us that if there were any deterioration with [person's] health the staff would act on this promptly.

Requires Improvement

Is the service caring?

Our findings

People on one unit did not receive care and attention like others. On this particular unit staff told us people received basic care and said there were not enough staff to provide anything more. The people on this unit were unable to tell us about the care and support they received. We did not see staff interact with people on this unit, unless they were assisting them with their personal care needs or their meal. However, on a different unit one person told us, "Since living here I have more positive days than bad days." They continued to say, "The staff are so supportive and they listen to you." Another person said, "The staff are lovely." A different person said, "Carers are fantastic they know what they are doing." We spoke with a visitor who said, "I am more than satisfied with the care provided to [person]. They told us, "You can't fault the staff or management." We spoke with a visiting care professional who said, "The care is good and the staff do well in caring for people with complex needs." We saw when staff entered the room they asked people if they were alright and engaged in conversation with them. We heard a staff member praise a person for the effort they had made to stop smoking. We observed that one person was unable to talk but smiled when staff spoke with them. We heard a staff member ask a person if they were comfortable in their chair or whether they wanted to rest on their bed. The person's preference was respected.

After the inspection one person contacted us and shared concerns about the care provided to them. They had raised concerns about the lack of support provided to reposition them whilst in bed to reduce their discomfort. They said the registered manager had not listened to their concerns and they felt unsupported. Further discussions with the person identified they were unaware of the advocacy service. We shared this information with the registered manager who assured us this person would be supported to access this service. Advocacy is a process of supporting and enabling people to express their views and concerns. Also to support people to access relevant services when needed. This service would help the person to express their concerns and to obtain the relevant support and care.

People told us they were involved in planning their care. One person confirmed their involvement in planning their care and their care reviews. They were happy with the care and support they received. We spoke with another person who said they could not remember being involved in planning their care. However, they said they were fairly independent and was satisfied with the service. We spoke with a visitor who said their relative did not have the capacity to be involved in planning their care. However, they were involved in their relative's three monthly care reviews. People's involvement in planning their care ensured their preferences were met.

People could be assured their privacy and dignity would be respected by staff. One person said, "Staff know when my door is closed, I want to be private and they will always knock on my door and wait." We spoke with a different person who said, "Before staff assist me with my personal care they close the door and the curtains." We spoke with another person who said, "Staff respect my privacy and when I want to be alone." We observed whilst a person was assisted with their meal the staff member wiped the person's mouth discreetly to maintain their dignity. Staff spoken with were aware of the importance of promoting people's right to privacy and dignity. One staff member said they always knocked on people's door before entering.

People were supported by staff to maintain their independence. One person said, "I feel I am building my confidence and independence again." A staff member told us about a person who had difficulty communicating. They told us the person was provided with a communication board to help them express their needs and we saw this. Discussions with the registered manager confirmed communication equipment were in place for a number of people. These included computers and specialized buzzers. Access to these equipment enabled people to communicate their needs and promote their independence. Staff informed us that people had access to specially adapted cutlery to help them to eat independently and we saw people using them.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported to pursue their interests and hobbies. On one unit where people were reliant on staff for all their care and support needs we observed very little stimulation. For example during the morning people were placed in front of the television with very little staff presence. Later we observed a staff member doing hand massages. Staff on this unit said they did not have time to provide meaningful activities or stimulation. We looked at one person's care record that lived on this unit. The care record showed the goal was to ensure the person had a good quality of life. However, we observed the only stimulation provided for them was a hand massage and a staff member on this unit acknowledged this. We shared this information with the registered manager who said this was a supervision issue. They said there were enough staff on this unit to provide people with stimulation. They assured us that measures would be taken to improve people's access to suitable stimulation.

We spoke with a person on a different unit who confirmed they had access to a variety of social activities. Another person told us they were actively involved in planning events like the summer party. They said, "There is always something on, staff always ask if you want to join in." They told us they had their own pastimes, such as watching the television and their electronic tablet. We spoke with a different person who said, "Sometimes I get involved with the activities and I enjoy playing bingo." A staff member told us about music therapy which was carried out weekly and said people really enjoyed it. We spoke with a visitor who said, "[Person] likes music and staff always puts this on for them." One person told us they always engaged in activities and said, "I am going to music class later." We observed a staff member take the time to sit with a person and helped them complete a puzzle. We also heard another staff member ask a person if they wanted to go for a walk. Next door to the home was a leisure centre and staff told us that people were supported to access the swimming pool there. We saw activities on offer were displayed in the home. For example, book club and coffee mornings. Arrangements for activities were in place for red nose day and mother's day. The registered manager told us about plans to have a sensory room. A sensory room is a special room designed to develop a person's sense, usually through special lighting, music, and objects. It can be used as a therapy for people who are unable to talk.

People told us they would share their concerns with the managers or the nurse in charge. One person said they had shared concerns about the staffing levels and the impact this had on them. They told us they were unhappy with the way their concerns had been managed. We shared this information with the registered manager for them to consider whether the person's concerns needed to be reviewed. We spoke with another person who said they have never had any concerns about the service they received. However, if they did they would share this with the nurse in charge or the registered manager. They said, "I reckon they would sort it out." We spoke with a visitor who said if they ever had any concerns they would speak to the registered manager. They were confident the registered manager would deal with this. Complaints were recorded and showed what action had been taken to resolve them. This also enabled the provider to monitor complaints to see if there were any trends.

People were actively involved in their care assessment and routine care reviews. One person said, "I was fully involved in my care assessment." Another person confirmed their involvement in their care

assessment. They told us their healthcare needs had changed and they had been involved in discussions about a more suitable placement for them.

People were supported to maintain contact with people important to them. On the day of the inspection two staff members had supported a person to spend the day at home with their family. We looked at one person's care record which provided staff with information about their preferred daily routine. For example, it told staff what time the person liked to have their breakfast. We saw the person was provided with their breakfast at that specific time. The care record informed staff that the person enjoyed watching television and we saw the person watching television after their breakfast.

Requires Improvement

Is the service well-led?

Our findings

People were at risk of their needs not being met because the provider's governance was not effective to assess, monitor or to drive improvements. We found the provider's governance was not effective to ensure all units within the home were adequately staffed or that staff supported people where needed. This placed people at risk of not receiving the appropriate care and support. For example, we spoke with staff member who informed us there were ten people living on one unit and five staff provided to care and support them. Two people required one to one support and another person required three staff to assist them with their mobility. They said whilst three staff assisted the person with their mobility there were no care staff available to supervise or care for the remaining seven people. We saw the nurse in charge of the unit with a person who required one to one support. They told us they had to stop administering the medicines to support the person as the care staff had to assist another person with their care needs. This meant people were at risk of not receiving the appropriate care and support.

The registered manager said there were eight nurse's vacancies which equated to 154 hours per week. Six care staff vacancies which equated to 246 hours per week. However, they told us these hours were covered by agency staff and they were confident there were enough staff on duty to meet people's needs. They said this was a supervision issue and staff were not where they should be. The registered manager told us it was the responsibility of the nurse in charge of each unit to ensure staff were available to meet people's needs. Although the registered manager said they routinely walked around the home to observe care practices and the availability of staff. We saw on one unit that staff were not available to care for people when needed.

People were not always supported to take their prescribed medicines. The provider's governance did not appropriately assess or monitor the management of medicine practices. For example, although medication administration records showed people had been given their medicine, we saw that these medicines had not been administered. Medicines that required cold storage were not stored at the recommended temperature has identified on the medicine packet. The provider's auditing system did not identify these discrepancies. This placed people at risk of receiving unsuitable medicines. The registered manager said the monitoring of the fridge temperature would be reviewed and monitored more closely. We found that not all staff who managed medicines were skilled to do so. The registered manager was unaware that untrained staff were administering medicines and assured us this would be addressed.

People were at risk of not receiving appropriate care and support with their tracheostomy. The provider's governance was ineffective to monitor and promote safe practices. The registered manager and staff were unable to demonstrate that people received the appropriate support with their tracheostomy care. One of two records we looked at relating to tracheostomy care informed staff about the importance of changing the inner tube every four hours. However, on one occasion this had not been changed for seven hours. This heightened the risk of the inner tub becoming blocked and the person being in discomfort. The registered manager assured us this would be looked at and action would be taken to address this.

One person told us about their health condition. We looked at their care record which informed staff about the support they needed to reduce the risk of their health declining. However, the staff we spoke with who

confirmed they cared for this person were unaware of vital health checks required to reduce the risk of the person becoming unwell. The provider's governance did not take the necessary steps to ensure all staff were aware of the importance of these health checks.

Some people did not have the same opportunities as others to purse their interests. The registered manager said everyone had the opportunity to pursue their specific interests. They were unaware that people on one unit were not offered the same support. The provider's governance did not assess or monitor people's access to social activities or to reduce the risk of social isolation.

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

People were encouraged to have a say in how the home was run. Meetings carried out with people enabled them to tell the provider about their experience of using the service. We looked at the minutes of one meeting that showed people had requested a trip to the potteries. Staff confirmed arrangements were in place to for this to take place. One person said, "The home seems well organised." The registered manager said that during a meeting, people were encouraged to be involved in naming the units. The registered manager said arrangements were in place to enable people to be involved in the staff recruitment process. People would be invited to sit on the interviewing panel. This would give them the opportunity to choose who worked with them. One person told us, "It's lovely here and I am comfortable and happy." Another person said, "I am here long term, I wouldn't go anywhere else, I am quite happy here."

The registered manager said meetings were carried out with staff team and staff confirmed this. A staff member said during a meeting they had made suggestions about improving record keeping. They said the managers gave them the opportunity to trial this. We received mixed comments about the management support provided to the staff team. A staff member said, "The management team are approachable, some more than others." They told us they didn't feel listened to. They said, "The managers are too busy and sometimes you feel like a number." Other staff spoken with told us they did not always feel supported by the registered manager and the clinical leads. They felt that managers did not recognise the complexity of their role in caring for people. A staff member said, "Staff morale is low." Another staff member said, "The managers very rarely interact with people and I am not sure if they know their names." We shared these concerns with the operation manager who assured us this would be looked at and addressed. We spoke with the registered manager about the culture of the home. They said, "It's like a big family, we work together giving people what they want." They continued to say, "We allow people to take risks." "We want people to feel comfortable and we enable them to decorate their bedroom to reflect their preference." We observed that the culture in different units varied. In most units staff engaged with people in positive manner and their approach was caring and attentive.

The registered manager confirmed they were supported in their role by the operation manager. The management team also included two clinical leads who worked closely with the nurses and care staff. The registered manager said they had access to routine training to ensure they maintained their skills. They had regular one to one [supervision] sessions with the operation manager. They said access to supervision enabled them to talk about future plans for the service, personal development and to obtain support where needed. The registered manager said they had aspirations to have a full and stable staff team. They wanted people to have the opportunity to undertake training with staff if they wanted to. Further discussions with the registered manager confirmed their awareness about when to send us a statutory notification about events that occur in the home which they are required to do by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance This is a breach of Regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's governance was not effective to ensure sufficient staffing were provided on all units. To monitor and assess the management of people's medicines. Or to ensure people's care needs were met appropriately and that everyone had opportunities to be involved in social activities.