Care Providers (UK) Limited

Ashcroft - Bromley

Inspection report

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05 December 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 27, 28, and 30 November, and 05 December 2016. At the last comprehensive inspection on 24 and 25 November 2015 we had found breaches of legal requirements in relation to staff recruitment, the accuracy of care records and systems to monitor the quality of the service. The provider had sent us an action plan to tell us how they were going to comply with legal requirements. We carried out a focused inspection on 27 April 2016 to check that the action plan had been completed and found that the service met legal requirements. However, we found the quality assurance system needed time to embed in order to demonstrate that issues were effectively identified and resolved.

The timing of this inspection on 27, 28, and 30 November, and 05 December 2016 was prompted by information of concern we received about the adequacy of staffing levels on some occasions. We inspected the service during the weekend and evening as well as during the day to follow up on these concerns.

We found there had been some occasions when there had not been the required number of staff at the home due to sickness and unreliability of agency staff. We were told by the acting manager and provider these issues had been resolved. At this inspection we found the staffing levels reflected the planned staffing requirements on the rota and there were enough staff to meet people's needs throughout the inspection.

Ashcroft provides accommodation and nursing care for up to 22 people with residential and/or nursing needs, including end of life care. On the days of the inspection there were 20 people using the service.

There was no registered manager in place. The previous registered manager had left in March 2016 and had recently submitted their application to deregister as the registered manager for the service with CQC. 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. The deputy manager had been acting manager since the registered manager had left.

At this inspection we found a breach of regulation because there were gaps identified in staff training and we were not assured of the provider's competency assessments for the delivery of internal staff training. You can see the action we have told the provider to take in respect of this breach at the back of this report.

We made a recommendation in relation to the safe management of medicines as there was no guidance for staff about people's 'as required' medicines. We also found that, while some improvements had been made, there was a need for other improvements to the quality monitoring and management of the service to ensure it was effective in identifying problems and learning.

Some staff did not feel well supported or well managed in their roles, and felt that their issues were not always addressed when raised. The staff team said they did not always work well together and that

communication could be improved. The provider told us they thought things were much better within the staff team following a recent staff meeting.

People told us they felt safe and well looked after at the home. Staff were aware of how to raise any safeguarding issues. Identified risks to people such as falls or from skin integrity breakdown were monitored and plans were in place to reduce risk. People who were nursed in bed were checked at regular intervals to ensure their wellbeing was maintained. There were plans in place to manage a range of emergencies. There were safe recruitment procedures in place. Medicines were safely managed and there were adequate systems to reduce the risk of infection.

People were well supported at the end of life stage of their care. The home worked in partnership with a local hospice to help people and their families prepare for this time, and supported people to have as pain free and positive experience as possible. The home had the highest level of award under a nationally recognised accredited framework for end of life care.

People were complimentary about the food and said they had enough to eat and drink. Nutritional risk was monitored and plans were in place to reduce risk. People had access to a suitable range of health care professionals and staff made appropriate referrals when needed to meet people's needs. Staff sought consent from people when offering them support. The service acted to comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) where people had been assessed as lacking capacity to make certain decisions about their care and treatment

People told us they were well looked after and we observed staff to be attentive and caring. Staff knew people's preferences and respected people's dignity. There was a warm atmosphere at the home. Relatives and visitors appeared relaxed and said they felt welcome. People's care plans provided an accurate record of their care and support needs. People's needs for socialisation were met through a range of suitable activities. There was a complaints system readily available and there had been no complaints recorded since the last inspection. People were involved in making decisions about their care and treatment.

Relatives and residents meetings were held to capture people's experiences of care and views about the home and the care provided. The acting manager told us an annual survey was completed to obtain people's and their relative views and the questionnaires were being sent out later that month.

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 safe.

Medicines were safely stored, administered and managed. Regular pain relief assessments were completed where needed. Some improvements were needed to the guidance for people's 'as required' medicines. We have therefore made a recommendation to the provider in relation to the management of medicines.

Risks to people were assessed and monitored and guidance provided to staff to reduce risk. There were arrangements to deal with emergencies.

Staff knew how to protect people from abuse or neglect. There were sufficient numbers of staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There were identified gaps in some nurse's training. Staff training certificates were not always available to verify completion of the training. Internal training was provided on some subjects, but we were not provided with any evidence to demonstrate the competence or qualifications of the training staff had been effectively assessed or verified.

Staff asked for people's consent before they provided care. They understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted to comply with this legislation.

People were supported to have a balanced diet and their dietary needs were assessed and monitored. People had access to a GP and other health care professionals when they needed it.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about their

relationships with staff and told us they felt safe and supported.

Staff displayed kindness, consideration, dignity and respect towards people. We saw positive and warm interactions between staff and people using the service.

People and their relatives told us they were involved in decisions about their care.

The home worked with a local hospice and supported people at the end of life stage of care. They held the highest level of accreditation under a recognised end of life framework.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed. Care plans were up to date and reflected the care and support given. Staff responded to changes in people's needs and regular reviews were held to ensure plans remained up to date.

There was a range of suitable activities available for people to take part in during the day and people were encouraged to use the local community where possible.

People had access to a complaints procedure. They told us they had not needed to complain but were confident any complaints would be addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

There was no registered manager in place. Staff views about the effectiveness of the management of the home were mixed.

Whilst improvements had been made to the monitoring of the quality of the service, the monitoring was not consistently maintained. Audits were not always effective in identifying where improvements were needed. Some records were not consistently completed.

People and their relatives felt the home was well run and that their views were listened to. We observed there was an open and caring culture, and staff were motivated to provide good quality care.

Ashcroft - Bromley

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 27, 28 and 30 November and 05 December 2016 and was unannounced. On the first day the inspection team consisted of two inspectors. On the second day of the inspection one inspector and an expert by experience carried on the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two inspectors returned in the evening of the second day. On the third day the inspection was completed by a single inspector.

Before the inspection, we looked at the information we held about the service including information from any notifications the provider had sent us. A notification is information about important events that the provider is required to send us by law. We also asked the local authority commissioners for the service and the safeguarding team for their views of the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the inspection 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. We spoke with nine people who used the service and four relatives, and we tracked five people's care to check that the care they received matched their care plan. We spoke with four nurses, seven health care assistants, the maintenance person, the activities coordinator, a domestic staff member and the chef. We also spoke with the acting manager and the provider.

We looked at five people's care records, four staff recruitment records, five staff training records and records related to the management of the service such as minutes of meetings, records of audits and service and maintenance records. After the inspection we contacted two health care professionals to gather their views about the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were safely administered. People told us they received their medicines on time and that they were always available when required. We observed part of a medicines round and saw that the nurse did not rush people and checked people's preferences about how they took their medicines. Where needed the nurse carried out pain assessments to ensure appropriate support. Controlled drugs were stored and administered in line with guidance, and recorded stocks of medicines were accurate. Medicines administration records (MAR) confirmed any allergies and were up to date. Checks had been completed for nurses to ensure their competency to administer medicines. People's medicines were reviewed with them by the GP, to ensure they remained appropriate to any changing health needs.

However some improvements were required. Current photographs were not always in place to confirm people's identity for any new or unfamiliar staff. Staff carried out detailed and regular pain assessments with people, but there were no guidance in place for staff on when 'as required' medicines should be considered for administration, in line with current guidance.

We therefore recommend that the provider refers to best practice and current guidance in relation to the safe management and administration of medicines.

People and their relatives told us there were usually enough staff on duty to meet their needs, although there had been some periods when the home had been short of staff which had meant them waiting longer for support or care. One person said, "Sometimes they have been short and then you have to wait a bit." Another person told us, "There is always somebody around if you need them." One relative commented, "There is always a staff member available."

Prior to the inspection we had received some concerning information about staffing levels at the home; particularly at weekends. We started the unannounced inspection at the weekend and also visited the home one evening to monitor staffing levels. We had found the numbers of staff on duty reflected the rota throughout the inspection and that there were sufficient staff on duty. During our inspection we observed people had call bells at close proximity and that they were answered promptly when used. We saw that people were attended to promptly and support provided at their own pace; people were not rushed. Staff rotas confirmed the staffing levels the acting manager told us were in place.

The acting manager told us that there had been some periods when the home had been short of staff, due to sickness and unreliability of agency staff, but this had improved recently. They were now using a different agency when they needed additional staff and this had worked well. They had also recently recruited staff which meant they had to rely less on agency staff. Last minute staff sickness at weekends had been addressed through a staff meeting and letter to staff, and there had been no issues with staff shortages at weekends since this had taken place.

Staff recruitment procedures helped ensure that people were protected from unsafe care. Adequate recruitment checks were undertaken before staff commenced work to confirm their suitability for work. Staff

records confirmed the necessary identity, character and criminal record checks had been carried out when people started to work at the service. The provider did not refresh criminal record checks, but staff were required to complete an annual statement to confirm if there had been any changes and were required to notify them immediately if this was the case.

People and their relatives told us they felt safe at the service and did not feel discriminated against, bullied or harassed. One person told us, "Yes I feel very safe. The staff here are good." Another person said; "The staff are very caring, and I feel perfectly safe." Hourly checks were completed to ensure the safety of people who were nursed in bed and may not have had the capacity to use a call bell.

Staff understood how to protect people from abuse. They were aware of signs of potential abuse and about the relevant reporting and whistleblowing procedures. They also told us they received regular safeguarding training. There had been one safeguarding alert since the last inspection and the service had cooperated with the investigation process.

Risks to people were assessed and monitored. People had risk assessments in place based on their individual needs. These alerted staff to possible risks and provided guidance on how to minimise identified risks. The assessments covered a range of possible risks, for example skin integrity risk, the risk of falls and nutritional risk. Plans were in place to reduce possible risk occurrence and these were regularly reviewed. For example people with fragile skin had a plan to support them using equipment such as a pressure cushion or pressure relieving mattress to reduce pressure on their skin. Where pressure areas had developed or people had wounds we saw there were additional records to track and monitor the progress of healing. There were manual handling risk assessments where people required equipment to mobilise, and guidance for staff about how to reduce the potential for falls for people when they mobilised.

Health and safety checks were conducted by the maintenance team to reduce risk to people living there. These included checks on water temperatures, beds and bed rails, and fire safety equipment. External service checks were made on equipment at the service such as electrical equipment, electrical installation, gas appliances, the lift, hoists and fire alarm and fighting equipment to ensure these operated safely and effectively.

There were procedures in place to deal with emergencies. The provider told us there was always a qualified first aider on duty at all times. Staff knew what to do in the event of a medical emergency or in a fire. They told us they had practised using evacuation equipment and that there were regular fire drills, so they were reminded about their roles in such an event. We confirmed the fire drills from records. People had an evacuation plan that detailed the support they need to evacuate in an emergency. There was a business contingency plan which had recently been reviewed to ensure contact details for a range of emergencies were up to date.

Requires Improvement

Is the service effective?

Our findings

We found a breach of regulatory requirements in relation to staff training and support. Most people and their relatives did not comment on staff training or competence, although one person remarked, "They seem to know what they are doing." However two relatives and a person using the service told us they felt that the moving and handling techniques used by staff could be gentler at times. A relative commented, "I think they could be more careful sometimes when they move people to protect them from bruising."

Staff training records for moving and handling showed they received training which was refreshed annually. Some moving and handling training was provided internally and some externally; staff confirmed this was the case and that this included practical training with equipment. The provider told us that they tried to get all staff on the local authority external training where possible. They also informed us internal training on the specific equipment that staff would be using at the home was important. We requested evidence of the training qualifications and competency of the staff member who delivered this training. However, the information provided did not reassure us that their competency in this area had been appropriately assessed or verified.

Staff attended other internal training courses across a range of topics the provider considered mandatory, such as infection control, safeguarding and Control of Substances Hazardous to Health (COSHH) training. Staff had certificates that showed some of this training was also carried out by internal staff and the previous registered manager. We asked for verification of their training and competence to deliver these training courses and we did not receive any documentation to confirm this. The staff member delivering COSHH training had signed their own certificate of training on COSHH in September 2016. This meant there was a risk that staff may receive training which did not ensure they were suitably skilled and competent.

We found ten unsigned internal training certificates, one for first aid and two for manual handling, which, were therefore not verified. The acting manager was not always able to identify who had undertaken the training in question when requested to do so. First Aid training certificates did not always include a date of expiry to advise staff when their training should be refreshed.

The provider had no guidance about what training nurses were required to hold to support people at the service. Only one nurse had any evidence of specialist feeding training and two nurses had no evidence of catheter care training in their records or venepuncture training, although there were people at the service who required support with specialist feeding regimes and catheter care. Not all nurses had evidence of first aid training and the provider told us this was because there were care workers who acted as qualified first aiders on shifts where a nurse did not have training. However we could not verify whether some care workers first aid training was still in date.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the provider and acting manager about our concerns about training. They told us they had

booked specialist feeding training for nurses for the following week.. The provider sent us a new training record that showed the training required of nurses and told us they were addressing the discrepancy between the certificates and the training records. We were not able to verify all this information at the time of the inspection.

Further improvement was also required with regards to supporting staff through supervision. Staff confirmed they received supervision to support them in their roles. However, some staff told us they had raised issues at supervision such as problems with other staff members, or staff sickness, but did not always feel these were acted on. Supervision records we looked at confirmed that most staff had received supervision in line with the provider's quarterly requirements. However three staff members had only received one supervision session in the last 12 months. Staff appraisals were overdue for five staff members and the acting manager told us these were being completed that month. We were unable to verify this at the inspection.

New staff told us they received an induction which included training, reading of care plans and a period of shadowing. They told us this had been helpful in learning about their roles. We saw there was a detailed induction programme which confirmed what aspects of the job staff had been observed to carry out or learn about.

Staff received additional training to help them in their role such as dementia care and palliative care training. One staff member said, "The training on end of life care is really good and useful for my work." A nurse informed us that they had recently attended advanced palliative care training at the hospice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

Staff understood the need to obtain consent before they provided care. One staff member explained, "Where people can't make a decision I give them a choice and look for signs of what they like." For those people who lacked the capacity to make a decision, staff understood the importance of checking people's ability to decide on each separate decision and to involve relatives and professionals as necessary in making best interests decisions. The acting manager knew how to submit a request for DoLS authorisation, and monitored the need for application and renewal of the authorisation forms to ensure authorisations were in place where required.

People were complimentary about the food provided. They told us there was plenty to eat and drink, and that they had a choice. One person said, "The food is excellent." Another person commented, "The breakfast is very good here." We saw the chef spoke with people about their dietary preferences during the inspection to confirm they were happy with their choices. A relative said, "The chef is very good, she really cares and wants to please people." We observed the meal time in the dining room and people were not rushed and had plenty to eat. There was a convivial atmosphere with people enjoying a conversation with each other

and staff. A choice of drinks was provided throughout the day, and we saw people nursed in bed had drinks beside their beds and were supported with these when needed by staff. People who were nursed in bed were supported, where needed, to eat in a dignified, calm and unhurried manner. The kitchen had scored the top score at the last Environmental Health inspection in October 2015.

People's care plans included assessments of their dietary preferences and requirements. Any allergies were clearly recorded. Where people required specialised support with eating and drinking we saw that appropriate referrals had been made and their needs assessed; with guidance in their care plan. The chef demonstrated a good knowledge of people's dietary needs and what foods they should avoid for any health reasons. However, some improvement was needed as, while there was information about the consistency of people's diets, there was no record of some people's specific dietary needs. For example there were no records in the kitchen of which foods should not be offered to people for health reasons, should the chef be unexpectedly unwell and replacement staff be needed to prepare meals. We discussed this with the acting manager and the chef and were informed that this was being organised as a priority. They confirmed this issue had been addressed following the inspection.

People were weighed to monitor for concerns about weight loss or gain. Where a person lost weight, they were referred to a dietician or GP when needed. People had daily fluid and food charts in place where risk assessments had identified that additional monitoring of people's intake and output was required.

People told us they were supported to maintain good health and had access to health care support from appropriate health professionals when needed, for example dentists, dietician, and opticians. One person told us, "They don't hesitate to call a doctor if you need one, and tell your next of kin." A relative said, "If there is something wrong with (my family member) they have picked up on it as quickly as we have, and acted on it." We saw evidence that staff were responsive to changes in people's behaviours and alerted relevant health professionals such as the GP or mental health team when needed.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person remarked, "They are very caring here." A relative commented, "[My family member] is well looked after here. I have no concerns." Another relative told us, "We are very happy with the care, they are dedicated staff." We observed staff interacting with people and their relatives in the communal areas at times throughout the day and there was a relaxed and friendly atmosphere. For example, we saw staff sharing a joke with people as they supported them. Staff were also mindful of people's changes of mood. For example, when a person became upset, we observed how staff reassured them and monitored their welfare. They demonstrated a good understanding of the needs of the people they supported and could describe people's preferences.

People were encouraged to maintain links with their relatives and friends. Relatives confirmed they were free to visit whenever they wanted and told us they felt welcome at the home. One relative said, "We are all welcome, the carers are lovely; they do listen." Another relative told us, "There are some very good staff here, who really do care. It's a small home and that's why we like it as it feels more like home."

People were involved in decisions about their care. People told us they were consulted about their care and that staff understood their diverse needs, and how they might be supported in maintaining their individual differences, for example with regard to their culture or spiritual needs. Staff understood the need to involve people in decision making. One staff member told us, "It's important to respect and consider people's wishes, at all times." Care plans indicated people's preferences and where they may be supported to maintain a level of independence. People's independence was encouraged, for example where they could manage aspects of their personal care, this was recorded in their care plan.

People told us they were treated with dignity and respect. One person commented, "Yes, staff are respectful, they knock first before coming in." We observed staff speaking to and treating people in a respectful and dignified manner. They were aware of the need for confidentiality and spoke discreetly to people when needed. They took their time and gave people encouragement whilst supporting them. A care worker told us, "When I support people with their personal care, I make sure the door is closed."

The home took an active approach to ensure people's preferences for the end of life care were listened to, recorded, and met. Relatives told us they had been treated with compassion and care when they visited. One relative commented, "I cannot fault the care that has been offered and the kindness and warmth of staff." The home specialised in end of life care and had close links for training and care with a local hospice. The home had been awarded the highest standard, Beacon status, in 2014 as part of the Gold Standards Framework (GSF). This is a recognised accredited framework to improve standards in end of life care. Beacon status is awarded to homes that demonstrate good practice and innovation across a number of standards.

A notice board provided information to staff and visitors on the home's approach to this aspect of people's care. Staff received training on end of life care and nurses told us that they were involved in more advanced end of life training with the local hospice. We saw people had advanced care plans where this was

appropriate, which recorded their wishes and preferences in the end stages of their lives. The hospice team informed us that the clinical lead at the home worked well with them and staff had attended a range of training. The provider was also involved in monitoring this aspect of the care to ensure people received good quality support at the end of their lives.

Good

Is the service responsive?

Our findings

People and their relatives told us they had a plan of their care. Records showed electronic care plans documented people's needs across all aspects of their care and support for example their needs at night, communication needs, personal care needs and eating and drinking. Care plans were reviewed as people's needs changed so that staff knew what support people required.

A pre-admission assessment of people's needs was undertaken by the acting manager to identify their care and support needs prior to them arriving at the service, and to check the home could meet their needs. We saw that care plans were written to address people's individual needs and preferences and there was guidance for staff on how to support people with their expressed wishes. For example, they explained what people felt able to manage independently and which aspects of care they needed support with. Guidance from health professionals was included in the care plans such as advice about fluid intake. There was information about people's life history for staff to use as a communication aid and to understand important facts about people and the significant people in their lives.

People told us there was enough for them to do, and their needs for socialisation and stimulation were met. We observed some people took part in dominoes, craft work and singing during the inspection. There was an activities organiser five mornings a week and we observed they consulted people about their preference for activities and if they wished to take part.

The activities organiser had arranged some outings in the warmer months for example to local garden centres and to a local pub, or the coast for those who wished to be involved. During the inspection we observed some people were engaged in the group activities. Those who preferred not to take part occupied themselves in their rooms, or chatted to each other or read in the communal area out of choice. One person commented, "The activities can be boring, but it's nice to gather around the table, just to have a chat with everyone." People who were unwell, or nursed in bed had music of their choice played in their rooms or watched television and listened to the radio.

People's spiritual needs were considered. Staff told us that a range of spiritual representatives visited the home regularly. One person said, "I actually take part in the service. It's very good, I look forward to it." Another person remarked, "It's very warm and comforting, I'm not religious but it is nice just to listen."

People and their relatives knew how to complain if they needed to and were confident any problems would be dealt with. One person said, "I've never had a reason to complain, I've never had an issue, but then I've not been here that long." There was information displayed about the home on how to make a complaint which was visible to people and any visitors. We checked the records and found that there had been no complaints in the last year.

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection on 24 and 25 November 2015 we had found a breach of regulation because there were inadequate systems to monitor the quality of the service and drive improvements. The provider had sent an action plan telling us what they would do to meet regulatory requirements. We carried out a focused inspection on 27 April 2016 to check on the action taken and found that the provider had introduced improved systems and processes to monitor the quality of care across the home. However, these needed time to embed in order to demonstrate consistency and effectiveness.

At this inspection people and their relatives told us they thought the home was well organised and managed. However our findings did not always agree with these views. One person remarked; "I think it's well organised here on the whole." A relative commented, "I've had no problems at all."
We found that some aspects of the system to monitor quality and reduce risk worked well but others required some further improvement to effectively identify and address areas for learning and improvement.

At the last comprehensive inspection on 23 and 24 November 2015 the provider told us they were looking to introduce the Care Certificate induction programme for new staff. The care certificate is a nationally recognised programme of training for staff new to health and social care. We asked to see evidence of progress with this objective but found no progress had been made. We saw from the hand over they had completed in March 2016 and a record from an audit visit in April 2016 that the acting manager had been asked to make contact with a training company in respect of this induction training but the certificate had not been introduced. The induction for new health and social care staff at Ashcroft therefore did not yet conform to recognised benchmarks of good induction training.

There was no system of spot checks carried out at night to ensure night staff were carrying out their roles as required. The acting manager told us they were about to start doing these. On the first day of the inspection we found one person whose care plan stated their fluid level required monitoring had no chart and two people's fluid charts were not being totalled to monitor their intake. These issues were addressed at the inspection but had not been identified through the provider's quality monitoring processes.

There were other aspects of monitoring quality and possible risks that were effective. Audits were completed for example on infection control, the kitchen, equipment and other aspects of the service. An external pharmacy audit had been completed In November 2016. The nursing staff had met to consider the issues raised and action had been taken to address the issues such as the fridge temperature and monitoring of stock. Accidents and incident reports were checked to identify any areas for learning. The previous registered manager also undertook staff recruitment record checks and monitored other internal audits to ensure issues were identified. For example one audit had identified the need to update a staff recruitment record.

The previous registered manager had stopped working as registered manager in March 2016. They had recently applied to deregister as registered manager. The home had been managed by the deputy manager as acting manager. They were aware of the requirements of a registered manager and the need to notify

CQC about a range of events. We spoke with the provider about their plans for a registered manager and he told us this was being reviewed in the next month.

Staff gave mixed responses about the leadership at the service. Some staff told us they did not feel supported in their roles and that staffing issues did not appear to be addressed by the acting manager or provider; for example issues about the rota. They commented that the staff team was divided and did not work well together which impacted on the atmosphere between them, as well as staffing levels and staff attendance. They said staff meetings were held but not everyone attended. Staff also commented that communication was not always clear and that they were asked to do different things by different people which confused them.

Four staff members told us they thought the home was well run and that staff did usually work well together. They said there had been some staffing problems but they thought these were now resolved.

We looked at the minutes from staff meetings and a heads of department meeting for 2016. Staff issues and concerns featured in these meetings held on 14 January 2016, 10 August 2016 and November 2016. Minutes of two meetings earlier in the year had not yet been typed up which meant staff did not have access to a copy of the minutes and any staff absent from the meeting had no record to refer to in order to be aware of current developments at the service.

We spoke with the provider and acting manager about the issues and they told us that they were aware of the problems and felt there had been a significant improvement in recent weeks. They had used staff meetings to try to address issues and they felt many issues had been resolved.

People's views about the service were sought people told us they were regularly consulted on an informal basis. One relatives and residents meeting had been held on 12 November 2016. The minutes confirmed that people's views were sought and there was a discussion about increasing the frequency to twice year. The acting manager told us that surveys were conducted annually and that these were being sent out later this month. Feedback was also sought informally from relatives, visitors and professionals when they visited.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive appropriate training, as was necessary to enable them to carry out their roles. Regulation 18 (2) (a).