Athorpe Health Care Limited

Athorpe Lodge

Inspection report

Falcon Way
Dinnington
South Yorkshire
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 May 2017 and was unannounced. The last comprehensive inspection took place in April 2015, when the provider was meeting the regulations.

Athorpe Lodge is a care home situated close to the centre of Dinnington. It provides accommodation for up to 90 people. The home is divided into six units; three providing nursing care (Balmoral, Buckingham and Sandringham) and three providing residential care (Hampton Court 1, Hampton Court 2 and Clarence).

At the time of our inspection there was a registered manager in post. 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. However, the registered manager was also registered at another service.

The provider had recently recruited a second manager who had been appointed to assist with the clinical aspect of the service. This person was in the process of registering with the Care Quality Commission. Throughout this report this person is referred to as the acting manager. It is the provider's intention to operate the service using two registered managers due to the size and complexity of the home.

People who used the service, and their relatives we spoke with, told us they were happy with how the care staff provided the care and support. They spoke positively about the staff and told us they were very caring. However, they told us the home was always very short staffed and that more staff were required as they had to wait to receive care and support and at times this was up to 45 minutes.

During our inspection we observed people had to wait at times for assistance and staff were not always present in communal areas to ensure people's safety. Staff told us at there was not enough staff to be able to meet people's needs. Staff we spoke with were aware they struggled to give person centred care, due to low staffing levels and felt very frustrated this was the case.

Assessments identified risks to people and management plans to reduce the risks were in place to ensure people's safety. However, we found these were not always followed.

Medicines were not always managed safely. We saw that temperatures of fridges used for medicines, were not constantly recorded. We also identified some concerns with the storage, recording and administration of medicines.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). There was a designated staff member who was responsible for the management of the DoLS and they had a good understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required.

The meals provided were well presented, nutritious and appetising. However, we observed staff did not always give appropriate support with meals to people who used the service. In particular we found people did not receive adequate hydration to meet their needs.

We spoke with staff and found they knew people well. They were aware of people's needs and their different preferences, but did not have time to meet these needs effectively. We looked at staff training records and they reflected that most staff had received training. However, updates were required to maintain the provider's expectations.

We looked at care files, although peoples choices were documented the care we saw delivered did not always reflect people's care and support needs choices or preferences. We observed staff at times were task orientated and care provided was not person centred.

The provider employed an activity co-ordinator and had recently appointed a second one to provide activities and social stimulation within the home.

The provider had a complaints procedure and people felt they could raise concerns. However, they didn't always feel that staff had time to discuss issues. We looked at the complaints record and found that concerns had been addressed in line with the provider's policy.

We saw that audits had taken place to establish whether the policies and procedure were being followed and to identify any areas of improvement. We saw that some concerns we highlighted as part of the inspection had not been adequately addressed.

The provider held residents and relatives meetings. However, people were only informed about the recent meeting at the last minute. We spoke with people and their relatives and most knew that a new manager had been appointed. However, people commented that they had never met them. This person had been in post approximately six weeks at the time of our inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We observed staff interacting with people who used the service and found there were insufficient staff available to meet people's need.

Risks associated with people's care had been identified and plans were in place to minimise the risk occurring. However, we found these were not always followed.

People's medicines were not always managed in a safe way. We identified concerns regarding the storage, recording and administration of medicines.

The provider had a safe recruitment system in place.

Is the service effective?

Requires Improvement

The service was not always effective

People did not always receive adequate nutrition and hydration to meet their needs.

Staff felt supported by their managers and told us they received supervision sessions. Staff training was completed, however, some updates were required to bring them in line with the provider's policy.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

We looked at peoples care plans and found that relevant healthcare professionals were involved in their care when required.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff showed concern for people's wellbeing in a caring way;

however they were unable to respond to people's needs quickly, due to staffing levels. On some occasions this led to task orientated care.

People's relatives told us that they could visit without unnecessary restrictions and felt part of their relatives care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were identified although these were not always met in a timely way.

People's preferences were identified in their care plans. However, They were not always considered when delivering care.

Activities were provided on different units. However, we found that people who spent time in their bedrooms, did not receive adequate social interaction.

Complaints were dealt with in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

We saw that audits had taken place to establish whether the policies and procedure were being followed and to identify any areas of improvement. We saw that some concerns we highlighted as part of the inspection had not been adequately addressed.

We spoke with people and their relatives and most of them did not know who the new manager was.

Athorpe Lodge

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 checked 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.

The inspection took place on 16 May 2017 and was unannounced. The inspection was carried out by two adult social care inspectors, a specialist advisor pharmacist and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. We were also joined by a member of the care homes team. This was a new role with a remit of looking at quality in care homes At the time of our inspection there were 82 people using the service.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We also spoke with the local authority and other professionals supporting people at the service, to gain further information about the service.

We spoke with 12 people who used the service and 8 relatives, and spent time observing staff supporting with people.

We spoke with 8 care workers, 2 nurses, the activity co-ordinator, the cook, the manager, and the registered manager. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at nine people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Requires Improvement

Is the service safe?

Our findings

People we spoke with this told us they felt safe living at the home. However, everyone we spoke with felt there were not enough staff available to meet their needs. One person said, "They try their best, but some days they are rushed off their feet. I can make myself a cup of tea but often people don't get offered a drink in the afternoons as staff can be tied up with more pressing things to do." They added, "Staff come as soon as they can, but sometimes I have to wait up to half an hour to be supported to the lavatory. If a member of staff is busy with a resident, it leaves one member of staff to cater for the other 16 residents.

Another person said, "For many weeks there were only two staff on duty to look after 17 people (Hampton unit)." A care worker raised the concern that they felt they needed three staff on the night duty the person felt this had been resolved. The provider informed us that this was a unit for up to 30 people and five staff were available to support people.

We spoke with relatives about staff availability and one relative said, "There are just not enough Staff. It's hard to pin anyone down. [My relative] was left soiled in his bed for forty minutes the other morning as the staff were busy with others. Staff are caring and work hard but there just don't seem to be enough to provide the level of care needed on the unit (Buckingham)."

From our observations and talking with staff, people who used the service and their relatives we found there was not enough staff to meet people's needs in a timely way. Staff we spoke with told us there was not always enough staff on duty to meet people's needs. On Balmoral and Sandringham units there was a nurse on each unit and two care staff. There was also one person who had one to one staff support, so there was one other care staff on duty to be able to provide this. However, staff said there should be an additional care staff to be able to work between the two units to provide support where required. One care worker said, "This has not been the case, on many shifts we are short, so we really struggle."

Relatives we spoke with told us more staff were required. One person said, "When I call for assistance the quickest they arrive is about 15 to 20 minutes and many times it is much longer. This is ok if you only want a drink, but if you need the toilet this is too long."

We found that one person on Clarence unit had waited 45 minutes for assistance and when the care staff arrived as they had waited so long they had not been able to wait for the toilet. This could have been avoided if there were sufficient care staff on duty to meet people's needs. We also observed a person was up and sitting in a chair in the lounge on Balmoral unit at 7.50am when we arrived. They were in front of the television but this was not on and there was no music, we saw no staff interact with this person as they were in people's rooms providing personal care. We observed this person was eventually moved to the dining room at 9.05am by care staff and was sat at a table with other people, who were given a drink and a cereal; this person had to wait until 9.40am, for care staff to be free to be supported the person with a drink.

Care staff also told us there were low numbers on nights so night staff were not able to get things done. This had a 'knock on' effect to the day staff and as such they were always trying to catch up. Staff we spoke with

were very frustrated and upset that they were unable to meet people's needs. Staff were aware they were becoming task orientated in providing care and support but told us, "It is not possible to do anything else when you are short staffed." One care worker said, "I know I am not delivering the appropriate care, but we just don't have time." Another care worker told us, "We miss out morning drinks as we don't have time, this means people are not being given enough fluids, we also don't have time to complete paperwork, so this gets missed." We saw dependency assessment in plans of care that identified people's dependency needs. However did not see how care hours were determined from this assessment.

The provider had a dependency tool in place which was used to calculate the number of staff required to support people's needs. This indicated that out of 82 people, 53 people were assessed as high or medium dependency. We looked at staff rotas and saw that there were some inconstancies in the calculated staffing levels and the number of staff on duty.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were insufficient numbers of staff to keep people safe and meet their needs.

Following our inspection the provider took appropriate action to address the staffing concerns we raised. The registered manager completed a night duty and other observations to determine what staffing levels were required. The registered manager acknowledged that more staff were required in some areas and we had confirmation that this had occurred.

People's medicines were not always managed so that they received them safely. We saw that medicines were sometimes stored inappropriately. We saw medication fridges were available for medicines which required cool storage. However, it was not always documented that temperatures of the fridges were taken daily to ensure they remained at an appropriate temperature. For example we found on the Balmoral unit, that the fridge temperature had gone above the recommended temperature on several occasions. Nothing was recorded as to what action had been taken to address this issue. We also found this fridge to be unlocked.

The provider had arrangements in place for storing and administering controlled drugs (CD's). A controlled drugs book was in place which was used to record all controlled medication. This was double signed in line with current guidance. We checked CD medicines and found the amounts in the CD books and the actual amounts were correct. However, we saw the key for the CD cabinet on Buckingham unit, was kept on top of the CD cabinet. The CD cabinet was too small for requirements meaning some medication was stored outside the cupboard. This was not following the provider's policy. We also saw on the Balmoral unit that cupboards used for storing medicines were very full and untidy. This showed that medicines were not always kept safely.

Medicines were not always administered in an appropriate manner. During breakfast we observed the nurse interrupt a person who was eating a hot meal to apply cream to their leg. This could have waited until they had finished their meal and been done in their bedroom. Another person had been prescribed two types of analgesic, that if administered they would have received over the recommended daily limit which could have had a detrimental effect. Although this had not been administered, this had not been identified as a potential risk.

We saw that several people required their medicines to be given covertly. We saw that one person had their medicines crushed. However one medicine they were prescribed should not have been crushed as this could cause an adverse effect. The acting manager confirmed that this practice had ceased following our inspection and the GP was informed.

We looked at Medication Administration Records MAR's) and found they were not always accurately completed to reflect medicines administered. For example, on Hampton Court unit, we saw 12 people had not received their morning medication on the day of our inspection, because they were asleep. Other gaps in the MAR's were noted and no reason had been recorded and/or the gaps left blank.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always ensure the safe management of medicines.

People who required medicine on an 'as and when' required basis, had protocols in place which gave details on how and when to administer the medication.

We looked at accidents and incidents which had occurred and found that these had been collated into a spread sheet. During April 2017 we noted that 81 accidents and incidents had been reported. The spread sheet identified the date, time and brief details of the incident along with action taken following the incident. However, no monitoring of themes and trends had been completed to identify if accidents and incidents could be minimised.

We looked at people's care records and found that risks associated with their care and treatment had been identified. Care plans had been put in place to help minimise the risk from occurring. For example, one person was at a high risk of falls and a floor sensor had been put in place their bedroom, to alert staff when the person was out of bed. However, we found that the identified care needs were not always followed. For example, one person had been identified as being at risk of developing pressure ulcers due to limited mobility. The management of this risk was to change the person's position every four hours when in bed and every two when sat out in a chair. We found the records identified this person was not provided with a position change following this criteria putting the person at risk of developing pressure ulcers as the identified risk management was not followed.

We also found this person had a completed body map in their care file dated 22 April 2017. This showed their skin integrity was at risk, however, there was no follow up information and the form had not been signed by staff to say it was resolved. The risk assessment was not being followed and inappropriate moving and handling was being provided to ensure the risk was managed. As a result the person was at risk of developing a pressure ulcer. This evidenced their needs were not being met.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not always doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

The provider had a procedure in place to safeguard people from abuse. We looked at the safeguarding log which was maintained by the registered manager. This kept a record of safeguarding concerns and the action taken along with the outcome. Most of the staff we spoke with were knowledgeable on safeguarding and whistle blowing policies and procedures. Whistleblowing is one way in which a staff member can report suspected wrong doing at work, by telling someone they trust about their concerns. Most staff told us they would not hesitate to report any safeguarding concerns. They told us if they felt the manager wasn't responding appropriately they would report to the regional manager or the local authority.

We saw the service had a safe procedure in place for recruiting new employees. We looked at four staff files and found the recruitment process had been followed. Pre-employment checks were obtained prior to new staff commencing employment. These included two references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing

unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people. The service was in the process of recruiting staff and was waiting for employment checks to be completed.

Staff files we viewed also showed that an induction had taken place with new employees and included training, and working alongside experienced staff for at least two shifts.

Requires Improvement

Is the service effective?

Our findings

We spoke with people who used the service and their relatives and they told us they were happy with the food offered at the home. One resident said "I've been on a diet, and they now send me up fruit every week from the kitchen. They [the staff] also make me Jacket Potatoes instead of chips and salads regularly." They added, "It's not the Ritz, but it's not Joes Café either. I sometimes have to wait for condiments to be brought as when staff put them on tables, other residents take them so we have to ask for them now."

People were not always supported to have enough to eat and drink to maintain a balanced diet. This was mainly due to staff not having enough time to support people adequately. For example, one person's food and fluid charts did not regularly record that they had been given mid-morning, mid-afternoon drinks and snacks or been provided with a supper. This person was at risk of losing weight. We saw a monthly weight chart which showed that this person had continued to lose weight. The Speech and Language therapist (SALT) team had been involved in December 2016, when recommendations about the person's dietary requirements had been made but no further advice had been sought in response to further weight loss.

We observed breakfast in the dining room on Balmoral unit. Staff did not start supporting people into the dining room until 09.05am. Some people had been up for nearly two hours at this point and had not been offered a drink. Although there was a variety of choice for breakfast, we saw one person had requested bacon and sausages, but was told there wasn't any. When we asked the care staff if this was offered at other times, they told us, "We do sometimes have sausage, but it is whatever the chef brings up." This meant there wasn't a choice and it was the chef that decided what was for breakfast.

We also observed the lunch on this unit there were no menus displayed on the tables. No information was available to show what the choice of meal was. Many people ate their meals in their rooms so staff were taking food to them this meant at times no staff were available in the dining room to offer assistance. One person was very agitated and kept asking questions and required reassurance, staff had to ensure they supported this person so this disrupted the meal service. The lack of staff impacted on the meal time experience as there were not enough staff available to ensure people's needs were met.

We observed lunch on Clarence unit. Although there was also no menu displayed on this unit we saw people were given choice and supported appropriately. People were also given a choice of drinks and we saw drinks were offered on this unit mid-morning. There were only two staff on duty but most of the people who used the service came into the dining room and did not require support with their meal, so this meant the staff could manage the mealtime effectively. Although the staff told us two staff at times struggled to meet people's needs.

Staff we spoke with were knowledgeable on people's needs in regard to their dietary requirements. Staff were aware of special diets and if they were at risk of choking. Staff had guidelines and assessments form dieticians and speech and language therapists to follow. However, we found adequate hydration and nutrition was not always given as people were not offered the support required to be able to maintain adequate hydration and nutrition.

Many people who used the service were living with dementia and the meal time experience did not meet their needs. For example, no picture menus displayed, when people were given choice the meals were plated up by staff and both shown to each person for them to be able to make a choice. We also found lack of support and encouragement form staff.

We looked at nine people's food and fluid monitoring charts and found they were not completed accurately and were not reviewed or monitored. This meant they were ineffective. Staff were recording ate half or a quarter but were not detailing how much was served so impossible to tell the amount that was eaten. The fluid charts showed people had not been offered a drink from 8pm on one day through to 8/9am the following day. This did not evidence people were receiving adequate hydration.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always supported to eat and drink enough and maintain a balanced diet.

We spoke with people who used the service and their relatives and they felt staff were trained to do their job and were knowledgeable about people's needs. One person said, "The staff training seems more than adequate. If relief staff cover and they don't know something, they will immediately find someone who does."

We spoke with staff and found they knew people well. They were aware of people's needs and their different preferences, but did not have time to meet these needs effectively. We looked at staff training records and they reflected that most staff had received training in subjects such as moving and handling, safeguarding, medication administration, and infection control. However, staff had not always been given the opportunity to attend refresher training to obtain updates and these statistics were low. For example, only 22% of the staff had completed update training in Malnutrition Universal Screening Tool, 58% had completed safeguarding updates and 43% had completed first aid updates. The acting manager had identified this shortfall and showed us a schedule of training which had been booked to meet the training requirements of the provider.

Staff told us they felt supported by the registered manager and the acting manager. The acting manager had devised a plan to ensure all staff received supervision on a regular basis. Supervision sessions were one to one sessions with their line manager. Staff told us they received supervision and support from their line manager. Staff told us that they worked well as a team and supported each other, but this was becoming very difficult due to lack of sufficient staff on duty to meet people's needs.

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 authorisation 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.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of

Liberty Safeguards (DoLS). There was a designated member of staff who managed the DoLS process. They had a very good understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. We looked at care files of people who had an authorised DoLS. We saw there was clear information for staff to understand the person's needs in respect of the authorised DoLS. Staff we spoke with were aware of who had an authorised DoLS and how this managed for the people they supported.

We looked at care records and found that most people were supported to maintain good health and have access to health care services. This was recorded in a section of the care records known as 'communication with people involved in my care.' For example, we saw referrals to speech and language therapists when people presented with swallowing difficulties. However, we spoke with one relative who said, "I have specifically visited today as my partner had a GP visit booked. On my arrival at the Home though, there was 'nothing on the list' and the appointment hadn't been made. I was disappointed. They [staff] have now made it for Friday, but it's still another few days of treatments being up in the air. There are thirty-odd rooms on this Unit with four carers at best. It's just not enough with the level of care that some residents' need."

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and their relatives and they all praised the staff, saying that they are very caring and attentive to their needs. However, one person said, "We have been promised named carers but that has not materialised yet."

Most staff showed concern for people's wellbeing in a caring way. We observed staff interacting with people on Hampton Court and found that some staff were person centred. One care worker spoke with a person about dancing which had been a previous hobby. However, on some occasions staff were task orientated and they were unable to respond to people's needs quickly, due to staffing levels. For example, staff were focused on the specific tasks. We observed one care worker standing up whilst assisting someone with their breakfast. They did not engage with this person, and called to another person who was on the corridor, to come for a cup of tea, speaking over the person they were assisting.

One relative we spoke with said, "The staff here are caring, but (my relative) hasn't been shaved again today, this is the third time. I know the staff were very busy with other residents but they should employ more staff if that is the case."

We saw a notice advertising that 'butterfly time' took place every day at 3pm. Butterfly time was when staff spent quality time with people. From our observations and from what people told us we found this did not take place.

People's needs and preferences were recorded in their care records. Staff were able to describe the ways in which people preferred to be supported, and were aware of information in the care plan, which included information about people's likes, dislikes, and life history. However staff told us they were not always able to provide person centred care due to staffing constraints.

We observed staff interacting with people and we found that they mostly respected people and maintained their dignity. Staff closed doors when delivering personal care and most staff spoke quietly when asking people something of a personal nature.

We spoke with people who used the service and their relatives and they told us they felt supported to maintain their relationships. People's relatives told us that they could visit without unnecessary restrictions and felt part of their relatives care. We saw that people's bedrooms were personalised and relatives had brought in personal items and photos to ensure their relative's room was familiar.

Staff understood the need to respect people's confidentiality and not to discuss issues in public, or disclose information to people who did not need to know. Any information that needed to be passed on about people was discussed at staff handovers, which were conducted in private.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us that staff knew what their needs were but did not always respond in a timely manner. People we spoke with felt involved in their care plan. One person said, "I am fully involved with my own care plan."

Care records we looked at identified people's needs, setting out how to support each person so that their individual needs were met. These were regularly reviewed when people's needs changed. However, we found these were not always followed. For example, people's moving and handling and nutrition care plans had not been followed to ensure their needs were met.

Care plans we looked at detailed people's needs and how they were met. We found people's choices and preferences were documented in plans of care but were also not always followed. For example one person stated they liked to get up and had been assessed by the occupational therapist and the correct equipment had been provided, but it took staff considerable time to be able to get them up and they did not always have sufficient time.

We spoke with staff and they were knowledgeable about people's needs, but were struggling to meet them in a timely way. Staff told us that they did not always have time to reposition people as often as they required and had to complete three hourly repositioning for one person when they had been assessed as requiring this every two hours. This person was at risk of developing pressure areas.

Another person's care plan we looked at stated they required support with eating and drinking, the care plan stated to provide support and offer regular snacks and record food and drink taken to be able to evaluate what they had eaten and if it was sufficient. The food and fluid charts had not been completed to be able to review and determine what they were eating and drinking. Although this person had not lost weight we found they had not received adequate hydration. On most days the maximum amount of fluids taken was 700mls there was no target amount recorded and there was nothing recorded on the charts we looked at, which covered a period of a month after 8pm until 9am the following morning.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's needs and preferences were identified but not always maintained in a person centred way.

We spoke with the activity co-ordinator who was employed to work at the home 48 hours a week. We were also informed that a second activity co-ordinator had been employed to work an additional 36 hours a week. The activity co-ordinator we spoke with told us they worked flexibly to meet people's social needs and worked their hours over seven days a week. For example, on one occasion the activity co-ordinator worked in the evening to support a person on a trip to the local pub to watch football. We also found that church services were available to people on a Sunday, and Saturday evenings were usually pamper sessions. Other activities included coffee mornings, bingo, music and movement, trip to local pub on a weekly basis. The home also had a mini bus which they shared with two other homes, but used this whenever they had this facility.

On the day of our inspection people living on Hampton Court joined in a sing-a-long session. One care worker said, "Music is a great way to interaction. Recently, two people who barely spoke were both singing along to a particular song." We spoke with people who used the service about activities and one person said, "There is often something going on and the co-ordinator is very good. Today is a sing-along." However, on the nursing units, where some people were cared for from bed, there was a lack of social interaction.

The provider had a complaints procedure in place. We saw this was displayed in the main entrance area of the home. We saw that the registered manager kept a log of complaints, which detailed the concerns raised and the outcome. We saw that complaints had been dealt with appropriately and in line with the provider's policy.

We spoke with people who used the service and their relatives and they told us they felt able to raise concerns. One person said, "I know the procedure if I ever wanted to raise a concern and I feel confident that it would be dealt with in the correct way." One relative said, "I know the procedure to complain but it is 'pinning someone down' to talk to them at times."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. The provider had acknowledged that a second manager was required to support the registered manager with the clinical aspect of the service. This person was in the process of registering with the Care Quality Commission. It was the provider's intention to operate the service with two registered managers due to the size and complexity of the home. However, the registered manager was also registered at another service. The management team also included four unit managers, senior care workers and team leaders.

We spoke with people who used the service and one person said, "I am little annoyed that the new manager (who's been in post a few weeks), hasn't introduced herself to the residents. There is a residents meeting tomorrow which I will be attending and I am sure that I will find out more things then." Another person said, "I haven't even met the new manager yet, I don't even know if it is a he or a she." We asked if this concerned the person, and they said, "My only concern about anything is that sometimes I have to wait a while for assistance due to not enough staff." Another relative said, "I've never been introduced to the new manager, indeed I've never even met them."

Staff told us that things were difficult at the moment as there was inadequate staff on duty to meet people's needs. Staff were very passionate about providing good standards of care and were extremely frustrated this was not able to be achieved. They felt the management were not listening to them in resolving this issue. Although they told us they felt they were a good team who worked together to support each other.
We spoke with the provider and the registered manager and acting manager. Who acknowledged that improvements were required and had started to implement some changes to the way the service was led. For example, new audit systems had been developed and the acting manager had been appointed to assist the registered manager in driving improvements.

The provider had an audit system in place to ensure policies and procedures were being adhered to. We found recent audits which had replaced the previous system. These audits included areas such as infection control, personnel, health and safety, pressure ulcers, accidents and incidents and catering. Any issues highlighted as a result of auditing, were entered on to a weekly action plan. The heads of every department, i.e. catering, maintenance, and unit managers, met with the registered and acting manager on a weekly basis. The purpose of this was to ensure they were aware of current issues identified as part of the audit process and to discuss the ongoing action plan.

Some concerns identified as part of our inspection, had been identified through the auditing system and placed on the weekly action plan. However, we saw that the provider's realistic timescales had not always been achieved. For example, the accident and incident audit had identified that an analysis was required to monitor trends. We found this was still outstanding. The action plan stated that the realistic timeframe was 30 April 2017. The care plan audit had identified that a review of people's weights was required. We saw that people's weights had been put in a spread sheet and the acting manager was in the process of taking action.

The weekly action plan did not refer to the issues we found regarding the service having insufficient staff to meet people's needs. We saw that one action was to observed practice of day to day running of all units. This was due to be actioned by 30 June 2017.

We saw that residents and relatives meetings took place. One person said, "There is a meeting tomorrow, but if I hadn't come on this visit today, I wouldn't have known about it. I haven't been notified in any other way." Another relative said, "The home is run well, but I haven't met the new manager yet. I have also only found out there is a meeting tomorrow where we will be told more. It hasn't been well advertised that there is a meeting though."

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Audits had identified some concerns but they were not always addressed in a timely manner.

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 9 HSCA RA Regulations 2014 Person-centred care People's needs and preferences were identified but not always maintained in a person centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always ensure the safe management of medicines. The provider was not always doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

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 Audits had identified some concerns but they were not always addressed in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff to keep people safe and meet their needs.