Primary Medical Solutions Limited

Goldenhill Nursing Home

Inspection report

Heathside Lane
Goldenhill
Stoke On Trent
Staffordshire
ST6 5QS

Tel: 01782771911

Date of inspection visit:
07 March 2017
08 March 2017
09 March 2017

Date of publication:
26 May 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service over three days, on 7, 8, 9 March 2017. This was an unannounced inspection. At our previous inspection we found the service to be meeting the Regulations.

At this inspection, we identified a number of Regulatory Breaches. The overall rating for this service is 'Inadequate' and the service has therefore been placed into 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

The service is registered to provide accommodation and nursing care for up to 44 people. People who use the service may have a physical disability and/or mental health needs, such as dementia. The service provides end of life care to people. At the time of our inspection 39 people were using the service. One person was in hospital at the time of our visit.

There was a registered manager at the home. 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 and associated Regulations about how the service is run. We were told that the registered manager was due to leave the service during the course of the inspection due to their concerns about the safety of people who used the service.

We found that there were insufficient staff working at the service and that the staff were not adequately trained to deliver the type of care that people using the service needed. We found some concerns with some of the staff, particularly those on the night shift, and their ability to communicate effectively with people due to language barriers. This posed a risk to people using the service.

Care delivery at the service was not always safe and this posed a risk to people's safety and well-being and staff were not always able to recognise and report abuse.

Staff were recruited safely and checks were made to ensure that they were fit to work with vulnerable people. However, we found some concerns with the recruitment process in terms of staff's suitability to work with people requiring end of life/palliative care. We also found concerns with some staff's ability to effectively communicate with people who used the service.

Staff were not adequately trained and we found that the induction did not equip staff with the skills and knowledge to care for people safely.

We found concerns with the food offered to people at the service. Food was not nutritional and did not promote people's well-being. Nutritional risk was assessed, planned for and monitored, however, there were not always sufficient staff to support people as they required with their eating and drinking.

People's privacy was not respected and their dignity was not maintained at the service. This was due to staffing levels and people having to wait to have their needs met. Staff lacked time to spend with people and care was often task focussed and rushed. At times, people were left without explanation or sat for long periods of time without any interaction.

People were asked for their views about how the service was run but these were not considered or acted upon. There were systems in place to gain feedback but this was not being used to drive improvement.

The registered manager was due to leave the service at the time of our inspection and they had raised several significant concerns about the safety and well-being of the people using the service. We found there to be an atmosphere of mistrust at provider and management level and found that areas of concern had not been addressed prior to our inspection, despite them being raised by people who used the service, their relatives and by staff who worked at the service.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were being following and steps had been taken to ensure that people's best interests and human rights were protected in relation to their care delivery.

Health professionals were consulted and referred to when people's needs changed or they became unwell.

Medicines were managed safely at the service and incidents notified as required by law. The registered manager carried out audits to monitor the quality of care delivery at the service. They had highlighted several areas of concern.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not being moved safely or re-positioned as required. Care was not always planned to keep people safe.

There were insufficient staff working at the service to adequately meet the needs of people.

Some of the staff we spoke with did not know what was meant by abuse or how to report it.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training and induction was not being managed effectively and staff lacked an understanding in key areas of care delivery.

The food at the home was not always nutritious and staff did not always support people as required.

The principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were followed to ensure people's human rights were upheld.

Referrals were made to health professionals when needed.

Is the service caring?

Inadequate

The service was not caring.

People's privacy was not respected and their dignity was not always maintained.

Staff did not interact with people using the service and offer explanations to them during their care delivery.

Some staff lacked the skills to be able to communicate effectively with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's views had not been considered or acted upon.

Care plans were individualised but staff lacked the time to deliver the care and treatment that people needed.

There were activities on offer to some of the people who used the service.

Complaints had been logged and responded to by the registered manager.

Is the service well-led?

Inadequate

The service was not well led.

Areas of risk within the home had not been addressed at the time of our inspection.

Staffing levels had not been adequately assessed and this had put people at risk.

There was an atmosphere of mistrust at the service between the manager and the provider and a negative attitude towards staff working at the service.

The registered manager carried out regular audits to assess the quality of care delivery.

Goldenhill Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 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 7, 8 and 9 March 2017 and was unannounced. The inspection team consisted of two inspectors, an expert by experience and a specialist advisor. Our advisor was a specialist in end of life care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also asked commissioners if they had any information they wanted to share with us about the service. We used this information to formulate our inspection plan.

Over the course of the three day inspection, we spoke with seven people who used the service, nine relatives, three nurses, two nursing assistants, the chef, an activities co-ordinator, 14 care staff, the registered manager and the provider. We viewed nine records about people's care and treatment which included their daily care records, risk assessments and medicines records. We did this to ensure that they were accurate, clear and up-to-date. We made observations of the care being delivered to people and pathway tracked people's care from planning through to delivery.

We looked at the systems the provider had in place to monitor the quality of service to ensure people received care that met their needs.

Inadequate

Our findings

People were not always receiving care to ensure their safety. During our inspection we found that staff were not moving people safely and were using techniques such as underarm drag lifts which put people at risk. A drag lift is where the carers place a hand or an arm under a person's axilla (armpit), to assist a person to change from one seated position to another. This is an unsafe and high risk practice which may cause injury to both the person and staff and is no longer considered to be good practice. We observed four separate incidents of this during our inspection. We saw evidence that this had been identified as an area of risk in staff meeting minutes we looked at, however, this risk to people had not been addressed.

Some people using the service were using pressure relieving cushions as they were at risk of skin damage. One person who used the service required a pressure relieving cushion to protect their skin, however, we observed several instances when this was not in place. This person had a pressure area during our inspection which developed into a pressure sore. This was the result of them not receiving the pressure care they needed at the time we inspected. Some people were being cared for in bed and required to be repositioned to protect their skin from damage. We found that some people at risk of pressure sores were not being turned as their care plans required them to be. One person was in the same position from 9am until 3.30pm. This person should have been re-positioned every four hours to protect their skin from any damage . We found that a record was falsified by a staff member during our inspection who recorded that this person had been turned at 2.30pm. As we had been to see this person at 3.10pm we knew that this hadn't been the case . We saw several turn charts where people hadn't been re-positioned as frequently as they needed to be. As some of the people using the service were receiving palliative care and needed nursing care, we found that care to these people wasn't being delivered to keep them safe. One staff member told us, "Turning people is a struggle." Repositioning charts did not always indicate how often people needed to be re-positioned so that staff knew what was required. Gaps in recording and staff not knowing when people needed to be repositioned was putting people at risk of damage to their skin.

Although people's care plans and risk assessments detailed their care needs, we found that risks were not always adequately addressed. For example, we found that one person had fallen 53 times over the course of a year. Some of these falls had no follow up actions documented and although referrals had been made to health professionals, there was not enough information for staff on how to keep this person safe. As the service relied on some agency staff and staff which were not always able to communicate effectively, it was unclear as to how these staff members would have known how to keep people safe. This put this person at risk of receiving care that did not meet their needs.

The above evidence constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that there were insufficient numbers of staff working at the service to keep people safe and deliver the care and treatment they needed. We observed people having to wait to use the toilet and to move around the home due to staff shortages. One person was told that they would have to wait to be moved into a wheelchair for their lunch-time meal until a staff member was available. When the person was transferred the wheelchair was found to be unsuitable for the person to sit in. People told us that they often had to wait for staff to respond to them. We spoke with seven people who used the service and five of them told us that there were not enough staff to meet their needs. One person said, "There are not always staff in this lounge. When there's no staff and you need help you have to shout. Sometimes you have to wait for help, sometimes for half an hour. The staff are kind. There has been lots of agency staff just lately, but mainly at night. Some of the agency staff don't speak a word of English and then it is very difficult." Another person told us, "I've been here a few years. It's very nice here but there is not enough staff. I press the buzzer and they just don't come."

We saw that, at times, people who were having one to one care were not receiving this as staff had to go and assist with other people. The registered manager and provider told us that they had not been aware that this was happening. This put people at risk as they required this care to ensure their safety and the safety of other people using the service. Two complaints had been raised with the registered manager about people not getting the personal care they needed due to staff not being available to do this. The care being delivered was not always safe or dignified for the people concerned.

We found that there had been a number of incidents at the service involving people assaulting one another. These incidents, although reported, indicated that people were not being kept safe and their behaviour was not being effectively managed as there were insufficient staff working at the service. We saw during our inspection instances when people's one to one care staff left them to assist other staff members. There was a risk that when this happened and people's care wasn't being delivered as needed that this put other people at risk.

Staff we spoke with described being rushed in their work and told us that they needed more staff to be able to deliver the care people needed. Some of the people at the service were there for palliative care as they had illnesses which meant they were not going to get better. Staff described being unable to provide this level of care to people as they were too busy and we saw that this was the case. One staff member said, "We need more time for palliative care. It's not just giving the medication and going away. We need to be with them." Another staff member told us, "It can be very difficult." Staff described having to support other staff members who did not speak English and being very rushed in their work. We saw that this was the case during our inspection and found that there were insufficient staff to meet the needs of the people who used the service. There was a reliance on agency staff who often lacked the knowledge of the people using the service to care for them safely.

We found that at night the staffing levels were inadequate. We visited the service early in the morning to speak with night staff and found that there was one registered nurse on duty and six care assistants. Three people required one to one care throughout the night and so there were three care assistants and one nurse for 35 people. 35 people at the service required nursing care. We found that three of the night staff were unable to communicate fully with us due to their language skills. It was not clear how these staff would be able to understand what people needed throughout the night as they lacked the ability to understand and communicate with people. As some of the people at the service had complex nursing needs and may have required pain relief and reassurance this put people at risk of unsafe care due to the number of staff on duty

and their ability to deliver safe care.

We asked the provider how they determined staffing levels at the home and whether this was calculated based on the dependency of the people who used the service. We were told that no dependency tool had been used and that there was no system in place to monitor responses to call bells. It was not clear how the staff numbers had been calculated and we found that they changed from day to day with no explanation as to why. We found that staffing at night was putting people at risk, both due to the number of staff on duty and their ability to deliver the care that people needed.

The above evidence constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about safeguarding people against the risk of abuse. Most of the staff we spoke with knew how to recognise and report abuse, however, some of the staff we spoke to on the night shift were unable to understand our questions and were not able to tell us how they would recognise and report abuse.

As some of the staff working at the service lacked an understanding about safeguarding, we could not be confident that people were adequately protected from the risk of abuse. The registered manager reported safeguarding incidents when they were made aware of them, however, there was a risk that, due to staff competence and understanding, incidents may have gone unreported. There were not adequate systems in place to protect people from the risk of abuse.

The above evidence constitutes a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were managed during our inspection and found that medicines were stored safely and that people received the medication they had been prescribed. The nurse on duty administered medicines to people with assistance from a nursing assistant where appropriate. People's medicines once administered were recorded as such and there was regular auditing of the medicines records by the registered manager to ensure this was being done safely. Controlled drugs were stored and administered safely.

Staff were recruited safely and checks were made to ensure that they were fit to work with vulnerable people. However, we found some concerns with the recruitment process in terms of staff's suitability to work with people requiring end of life/palliative care.

Requires Improvement

Our findings

We looked at the induction staff were given when they started working at the service as some of the staff we spoke with did not have experience of working in care. We found that the induction took place over one day and involved a large amount of information. We spoke with the registered manager about the induction who told us that the one day induction covered moving and handling, fire safety, infection control, health and safety, familiarisation of the service, documentation and a briefing on "routines". This took place from 9am until 5pm. From our observations of staff delivering care it was clear that staff had not been adequately trained in relation to moving and handling as staff were not using correct procedures to move people. Staff told us that they had raised issues around training with the management and that these had not been addressed.

We were told that the majority of training took place on-line and this included delivering care to people who were approaching the end of their life. We saw some gaps in training in relation to safeguarding vulnerable people and in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We found that staff did not always have a good understanding of the MCA and we observed poor practice in relation to moving and handling people which indicated that the training and induction had not been effective. We asked the registered manager about the quality of the training and they told us that they did have some concerns about the quality of training at the home and said that they had tried to get this reviewed. They described the induction as "very poor" and were not confident that it would adequately equip staff to do their jobs. We saw that this was the case during our inspection as staff were using underarm drag lifts to get people up from their chairs. The registered manager and provider were unaware that staff were using these practices when we raised this with them during the inspection, indicating that staff performance was not being effectively monitored. Some staff lacked a basic understanding of safeguarding and failed to tell us what the MCA covered. These were areas of care that staff needed to have knowledge of, however, we found that this was not the case.

We spoke with staff on the day shift to ascertain if they understood safeguarding procedures and how to report and recognise abuse. Most of the staff were able to tell us about the different types of abuse and knew how they would report them. Staff were less clear on the requirements of the MCA, however, we did see consent being obtained from people before care was delivered to them. Three of the night staff we spoke with were unable to tell us how they would report abuse and were not clear on the requirements. We raised this with the registered manager who told us that this would be addressed following our inspection. This indicated to us that staff had not been adequately trained in this area of care and that they lacked an understanding of the requirements here.

As some of the people using the service required specialist palliative care it was not clear how the service was ensuring that staff were adequately skilled and competent to deliver this kind of care to people. There was no specialised training in this area of care and we were concerned that some of the staff we spoke with were unable to communicate with us due to language difficulties. We could not be assured that people were receiving the care and treatment they needed through the night as some of the staff we spoke with were not able to communicate fully with us. As there was one registered nurse on duty through the night to people requiring nursing care, of which there were 35, they may not have received the care and treatment they needed.

The above evidence constitutes a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who used the service and their relatives about the food provided. Several people were unhappy with the food. One relative told us, "I sometimes sit with [my relative] in the dining room where lots of people need support to eat, sometimes the staff are a bit tetchy with one another as they have so many people to support. Sometimes the food is only just warm." Another person who used the service told us, "I don't like the food, doesn't seem to be any choice, you have what's put in front of you. I have enough to drink." People described being given enough to eat and drink, however, we observed staff struggling to assist people to eat in a timely manner due to staffing levels at the service and at times this impacted on people who should have been receiving one to one care.

We observed lunch-time on two days of our inspection and found that this was not always a pleasant experience for people. Staff were rushed and struggled to meet people's needs and food was left out on a counter in the kitchen for long periods of time. We were told that food that went to the upstairs dining room on a trolley with no heat was sometimes cold by the time people received it. We were told that in this instance the food would be re-heated in the microwave. We looked at the food stock in the kitchen and found a limited supply of fresh food and a large quantity of tinned and processed foods. We spoke to the chef at the home about the amount of fresh fruit and vegetables at the service and they told us that there was only one person who ate fruit. We reviewed the menus and found that the food was of poor quality and often lacked nutritional content.

We saw that people's weight and their nutritional risk was monitored at the service. All of the people using the service were weighed at least monthly and more if they were deemed to be at nutritional risk. The registered manager checked the weights and recorded any significant weight loss over time. We saw that referrals were made to dieticians and other health professionals where this was needed and when concerns were identified with people's nutritional risk.

Some people who used the service were unable to make certain decisions about their care. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people's best interests, when they lack sufficient capacity to be able to do this for themselves. We saw that mental capacity assessments were completed when required. The registered manager was aware of the current DoLS guidance and had identified a number of people who could potentially have restrictions placed on them to promote their safety and wellbeing. The registered manager had made referrals to the local authority when they thought someone may be unlawfully deprived of their liberty and we saw evidence of this. However, staff we spoke with lacked an understanding of the MCA and may not have been able to recognise when someone was being restricted of their liberty or when they may have needed a mental capacity assessment.

We found that referrals were made to health professionals and saw that health professionals frequently

visited people at the service. The registered manager monitored people's health and well-being and had good relationships with the professionals who came to the service to assess and deliver care and treatment to people. We spoke with one health professional who told us, "I've not had any major concerns. I think it's a very busy home." The professional was very positive about the input from the registered manager and went on to say, "The patients are quite complex."

Inadequate

Our findings

Staff lacked time to spend with people and we saw several instances where people were left for long periods of time without any interaction of any kind. We also saw times when staff supported people with a hoist, failed to explain what they were doing and why and failed to seek people's consent. Staff were busy in their work and there was a task focussed approach to care within the service. This meant that people were not given individualised care to meet their needs. During our inspection we saw people having to wait to do what they wanted due to staffing levels and this was not dignified for people who used the service. For example, one person wanted to sit next to their spouse. Staff told this person that this wasn't possible as there weren't enough staff to help them to do this. This caused the person distress and they remained where they were.

We looked at the record of complaints at the service and found that one person had raised a complaint about not being dressed in the morning. The complaint detailed that the person had still been in their bedclothes at 12.50pm. This person had not had any personal care delivered to them and attributed this to a lack of staff. This had impacted on this person as they submitted a written complaint to the service in which they expressed frustration about this. People could not always spend their time as they wished as there were not enough staff to support them and this impacted on their dignity.

We observed lunch-time during our inspection and found that in one lounge there was one staff member for seven people. We were told that five of these people needed two staff members to mobilise. We asked how people would be able to go to the toilet if they needed to. We were told that the staff member would need to call for a staff member and wait for them to become available. We saw staff struggling to meet people's needs in this dining room. One person was walking around and the staff member had to keep calling them to come back into the room as they were going into people's bedrooms. This was not dignified for the person using the service or for the people whose rooms this person was entering. People's privacy and dignity was not being maintained at the service. Another person was being hoisted into a wheelchair during lunch-time by two staff members. This person had needed to wait 10 minutes for this to happen as there were not enough staff to do this. Once moved into the wheelchair staff noticed that it was broken and not suitable for the person to sit in. We looked at the wheelchair and found it to be dirty and in a state of disrepair. This meant that this person was left for several minutes in a dirty, broken wheelchair waiting for a suitable alternative to be found. This was not dignified for the person using the service.

One staff member told us that agency staff were coming into the service to "observe care in practice" in order for them to decide whether they wanted to work in the care sector. These agency staff would observe

care being delivered to people at the service. This was being done without the consent of people who lived at the home. We raised this with the provider who informed us that this had been done at the service. This was an invasion of people's privacy and the provider had failed to consider the impact of this on people who used the service. This did not indicate a caring approach to people.

The above evidence constitutes a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were caring towards them and we saw some positive interactions between staff and people using the service. However, we found several instances where staff failed to effectively communicate with people whilst delivering care and support to them. Some staff did not interact with people they were assisting to eat and we saw that staff would often leave people to assist other staff members without any explanation or any apology when they returned.

We had significant concerns about some of the staff we spoke with who delivered care throughout the night to people. Some of the people using the service were there for palliative care and most people needed nursing care. As some of these people may have needed pain relief or reassurance through the night we needed to ensure that staff were able to provide this. We found that there were six care staff working throughout the night and that three of the staff we spoke with were unable to answer some of our questions due to language difficulties. One staff member told us, "Daytime is difficult to understand as everyone is awake." We were concerned about staff's ability to be able to know and understand what people needed throughout the night and their ability to effectively communicate with people should they have needed any emotional support. We raised this with the registered manager who assured us that following our inspection only staff who could communicate effectively would be on duty to support people. However, we were told that staff supplied by an agency and who lacked the ability to communicate with people had regularly been working at the service.

Care records we looked at did contain personal information about people and the registered manager knew people well. However, staff delivering care to people did not always know people due to the numbers of agency staff being used. Regular staff at the service understood people's needs, however, they told us they lacked the time to spend with people and that care delivery was often rushed. One staff member said, "We are doing our best. We need more time for palliative care." Another staff member told us, "They're end of life, they need that extra care spent with them." We observed people being left in their rooms for long periods of time with little or no interaction with staff who lacked the time to sit with people or to provide the reassurance some people may have required. People approaching the end of their life were not getting the level of care they needed.

Requires Improvement

Our findings

Some people we spoke with did not feel that they could express their views about how the service was run and told us that they had not had the opportunity to do this. Some people stated that they had done this but that their feedback had not been considered. One person said, "I've not been asked for my opinion on the service". Another person told us, "I've never been asked for my opinion". The relative of someone using the service told us, "I attend the relatives meeting that are held about twice a year. I feel you can speak up at the meetings but no real changes are made. For example, about 15 months ago we were told the home was to be decorated, it was only last month or so that a paintbrush was in evidence." People told us that they could approach the registered manager at any time but some people felt that their feedback was not always acted upon.

We looked at some minutes from a "Residents and Relatives Meeting" which had taken place at the end of November 2016. These stated that, "Concerns were raised regarding the light outside the entrance area, decoration of the home, the lounge windows, some of the staff ignoring visitors, staff training, sometimes lounge is not supervised, the manner in which staff interact with residents, residents being left in wheelchairs for long periods, language barrier, hot food served on cold plates and poor response from the staff when concerns addressed." We found that some of these issues, although raised, had not been addressed by the provider despite them being aware of them for some time. For example, we observed people being left for long periods of time and staff failing to interact with people. We also identified an issue with the temperature of the food, although the provider told us that they would address this once we had spoken with them about this. Staff continued to work at the service who lacked the ability to communicate with people due to language barriers. People's views were not always listened to at the service and some improvements to the home had not been made, despite people raising them as issues.

We looked at people's care records and found that they reflected people's individual needs and that they were written about the person they concerned. They contained information about people's preferences for their care and treatment and demonstrated a person-centred approach to care planning. However, we found that due to staff shortages at the service and staff being brought in who lacked the knowledge to provide individualised care, care was not always responsive to people's needs. For example, we found that people were not being re-positioned as often as they should have been and that staff lacked any time to ensure people were getting the right kind of care. We also found examples where people's personal preferences were not met, for example in relation to when they got up and dressed and how they spent their time. The registered manager knew people's needs well, but they did not always have the time to ensure that people were getting the care and treatment they needed due to the demands of their role.

There was an activities co-ordinator at the service and we saw that activities were made available to people. The activities co-ordinator was at the service throughout the week and we saw that activities such as games were offered to people in the communal areas of the home. People who remained in bed were not always offered any kind of stimulation and we saw people left for long periods of time in bed with little or no staff interaction.

We found that complaints were logged and responded to at the service. We saw that people who used the service had raised complaints when they needed to and that these had been considered and dealt with by the registered manager. There was a complaints procedure readily available to people and their relatives should they have needed to complain. Compliments about the service were also logged and recorded.

Inadequate

Our findings

People and their relatives were positive about the registered manager at the service. The registered manager was also one of the company Directors, however, was due to leave the service due to disagreements about how it was being run. People described them being a key part of the service and felt that they could approach them should they need to. One person said, "The manager is lovely, he has an open door policy." Another person told us, "I know the manager, he is very nice, he comes and asks how I am, he listens." People's relatives felt that the manager was visible but felt that issues raised were not always adequately addressed in a timely manner. For example, one person had raised an issue about the safety of the door leading to the stairs on the first floor. They told us, "I am unhappy that there is not a proper fastener on the gate at the top of the stairs, it's been like for at least six months. I even wrote about it on the questionnaire I completed in November 2016 but it's still not sorted." We asked the registered manager why things that people had raised had not been addressed. They told us that this was due to financial constraints placed on them at the service. When we raised the issue with the provider they assured us that this would be rectified immediately. It was not clear why this had not been addressed prior to our visit due to the risk it posed to people using the service.

We found that staff were not always adequately trained, particularly in relation to the types of care they were delivering. Some of the staff working at the service lacked the skills to be able to communicate with people effectively. The registered manager had been aware that this was an issue as we saw that it had been raised in staff meetings and in meetings for people who used the service and their relatives. However, no action had been taken by the provider to address this shortfall within the service to protect the people using the service. This was putting people at risk. The registered manager told us that they had raised their concerns about staff training and competence but that these had not been addressed. Although we found evidence that some staff supervisions took place, the provider and registered manager had failed to monitor staff competence and performance adequately.

Staff received regular supervision, they told us they felt supported by the registered manager and that they could approach them should they need to. However, staff did tell us that they were concerned about staff turnover and staffing levels and that this impacted on their ability to do their job. One staff member said, "Sometimes you have really bad days. They drop the numbers then they put them back up." Another staff member told us, "My main concern is the staff they're employing and the language barrier." We found that issues raised by staff and people using the service and their relatives about the staffing arrangements at the service had not been considered or addressed and that this indicated a failure to quality monitor effectively and improve the service accordingly. These staffing concerns were putting people using the service at risk.

We looked at how the service received and responded to feedback from people using the service and found that, although they were made aware of issues, the provider had failed to respond to many of the concerns raised. We also looked at staff meeting minutes and found that there was a negative tone to the way in which the management and the provider communicated with staff. We found that staff were criticised and blamed for failings at the service. We raised this with the registered manager who told us that they would look to rectify this following our inspection.

We found that there was some unrest and instability within the management team at the service. There was an atmosphere of mistrust between the providers and the registered manager which was not productive and which was impacting on the service. We were told that the registered manager was due to leave the service at the end of the month due to the lack of support they were receiving in ensuring people's safety. The registered manager identified areas of risk within the service and informed us that they had made the provider aware of this but that no action had been taken. We did not find there to be a stable management structure in place at the service at the time of our inspection and nor did we find evidence of a drive for improvement from the provider.

The above evidence constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager carried out regular audits in relation to key areas of risk within the service. These audits were done for falls, medication, nutritional and environmental risks. The registered manager carried out these audits and we saw that they were documented with outcomes and that issues were addressed as needed. These audits had picked up issues with the quality of care being delivered at the service.

The registered manager ensured they notified CQC of significant events that they were aware had taken place at the service.