Heritage Care Limited

St Audrey's

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

St Audrey's is registered to provide accommodation and personal care for up 38 older people. At the time of our inspection 27 people were living at St Audrey's.

The inspection took place on 26 November 2015 and was unannounced which meant the provider did not know we were inspecting. At this inspection we found breaches of regulations 10, 11, 12, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have served warning notices in relation to Regulation 12 and 17 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. We will check that the provider has taken action to remedy the concerns identified.

The home had a registered manager in post who had been registered since September 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found there were insufficient numbers of staff were deployed to provide care safely to people living in St Audrey's. The registered manager had not made arrangements to review and investigate incidents and accidents to keep people safe from the risk of harm. Risk assessments had not always been developed to positively manage risks. People's medicines were not always stored safely and information was not always available to staff about how to manage medicines. People were supported by staff who had undergone a robust recruitment process to ensure they were of good character to provide care to people.

Staff felt supported by the manager who enabled them to carry out their role effectively. Staff received training relevant to their role; however we found that temporary (Bank) staff were not provided with sufficient training to feel confident in their role.

People's nutritional needs were met however their food and fluid intake and weight was not robustly monitored. People were able to choose what they ate from a varied menu. People we spoke with told us they had access to a range of health professionals. Records demonstrated they were referred to specialists when their needs changed and this was confirmed by visiting professionals.

Staff spoke to people in a kind, patient and friendly way. People's dignity was maintained, however we observed people were not assisted promptly to change their soiled clothing after lunch.

People did not receive high quality care that was well led and regularly monitored. People's personal care records were not regularly reviewed, completed or updated when required, and people felt the manager was not as visible around the home as they should have been.

As a result of this inspection the provider agreed to restrict further admissions to St Audrey's until such time

as there were sufficient numbers of staff and they were deployed effectively to meet people`s needs safely at all times.

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

People were not always safe.

People were not cared for by sufficient numbers of staff.

People's medicines were not managed and administered in a safe manner.

Incidents and accidents had not always been sufficiently monitored or responded to.

People were supported by staff who had been recruited following a robust recruitment process.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for by a regular staff team who felt supported; however temporary staff did not receive the same level of support.

People's consent had been obtained prior to care being delivered, however the requirements of the Mental Capacity Act 2005 had not always been followed.

People were not always supported to eat sufficient amounts and people's weights were not always monitored.

People were supported by and had regular access to a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People were spoken with in a kind and respectful manner, however their dignity had not always been preserved.

People felt that the staff were compassionate and kind and supported their independence.

People were encouraged and actively supported to develop and maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual social needs were not always supported.

People felt their views were listened to and that they were able to influence their care.

People were aware of how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not well led.

Systems were not effective in assessing and reviewing the quality of care people received.

Records relating to peoples care were not always accurately maintained.

People felt that the registered manager was not as responsive or visible as they could have been.

St Audrey's

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 met 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 under the Care Act 2014.

This inspection took place on 26 November 2015 and was unannounced. We carried out this inspection following the concerns raised with us that St Audrey's may not have sufficient staff to care for people safely. The inspection was carried out by one inspector, a specialist nursing advisor 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 service.

We reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed how staff offered support to people who used the service. We spoke with seven people who used the service and two relatives, seven staff members, the registered manager, deputy manager and members of the senior management team..

We received feedback from a healthcare professional and from a representative of the local authority social working team. We also 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 reviewed care records relating to four people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Inadequate

Is the service safe?

Our findings

People's medicines were not managed safely. We identified that people did not always receive their medicines at times they had been prescribed them. We found that one person who required medicines for management of their Parkinson's had not received these for a period of six days. Staff had identified that stocks of the medicine had run out, and had ordered a resupply; however, no other staff members on the preceding six days had either reported this to the manager, or chased the order to ensure the person received their medicine.

We also found that a change to a persons prescribed dosage for one medicine for a heart condition had not been amended by staff. The GP had reviewed this person's medicine, and increased the dosage. However this varied dosage had not been given to the person since the alteration in October 2015. This meant that people had missed important medications that could impact on their health and well-being.

When we looked at the medicine records we found that where staff had not given medicines to people, there was no consistent explanation recorded as to why. For example the person who had not received their Parkinson's medicine, had a record placed in the record to state that it had not been administered for 'Other' reasons. When we looked on the rear of the record, it had been completed until 21 November 2015, however no other reasons or follow up actions were recorded. Staff had documented on they had sent a fax and were awaiting stock, but this did not prompt any staff member to take responsibility and ensure these were collected.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents were logged by staff and sent to the manager. They manager reviewed, investigated and referred people to the local safeguarding authority if it was necessary. Staff had recently been asked by the manager to complete daily body maps of people. They recorded any injury, scratch, blemish or bruise, and a senior staff member reviewed these at the end of each week. If there were any concerns raised from these weekly body charts they were then reported to the management team. Where incidents, injuries or concerns relating to a person safety were reported, we saw these were effectively reviewed and appropriate actions taken.

However, we found that not all incidents were received by the manager. We saw that staff used an email system to send the forms to the manager. In a number of examples, incidents had not been received because the incorrect name was entered into the email field. For example we found that on several occasions, accident and incident forms were not received by the manager regarding a person who was considered to be high risk of falling. The management team did not have a system in place to ensure that all incidents were reported, meaning incidents and injuries had gone unreported, and the associated risks unwire not reviewed in people's care plans.

We also found that incidents were not reviewed for patterns themes and trends to mitigate the risk of

repeated falls or injuries. This meant that people were not always protected from harm or unsafe treatment because a system of reporting, reviewing and identifying risks to people was not robust or consistent. However, we were able to see where following a fall resulting in injury to one person; the provider discussed the incident at the next management meeting. Matters were discussed and lessons learnt and shared. For example, as a result of this incident, all services were asked to consider the risk of individuals trying to use the stairs.

The registered manager told us that the home was moving over to a computerised system that would enable them to monitor and review incidents and injuries in a more robust manner.. We saw that where incidents were logged, staff had completed body maps and photographed the injury so that the progress could be monitored effectively. We spoke with the provider about the inconsistencies in incident reporting and investigating. They told us they were aware that the systems required reviewing and were in the process of addressing this with the manager.

There were whistle blowing and safeguarding policies and procedures in place. Staff we spoke with were confidently able to describe what constituted abuse and said that they would escalate any concerns they had. Staff members told us that they had received training to support them to understand the different types of abuse that could occur and they were able to tell us of contacts, both within the organisation and of external organisations, to whom they could report any safeguarding concerns. However, people had not been protected from harm due to both insufficient experienced and qualified staff deployed, and the safe management of people's medicines. Systems and processes had not been operated effectively to prevent abuse of people who used the service. □
There were not enough suitably skilled or qualified staff deployed to provide care for people. They told us they had reviewed the staffing numbers based against people's needs and were unable to provide sufficient staffing levels should the home be fully occupied. They told us that were using a high proportion of temporary agency staff and felt that people would be at risk if they were to take further people into St Audrey's. They said that due to the lack of permanent staff people experienced care that was at times inconsistent and not always responsive to their needs.

Recruitment had been an area that the manager had found difficult. They told us that they had recently recruited a deputy manager, two care team leaders, and three care staff in the previous nine months. They said, "Staffing is an issue, but we are not going to recruit anybody who comes along, they have to be the right type of person."

We looked at the response times for when people pressed their call bells. These varied from one to two minutes up to seventeen minutes in one example. Many of these calls were made during the night when people were more vulnerable and may have been in need of immediate attention to prevent any accidents from happening. One person told us, "Poor old [person] was left on the toilet for ages a while ago, there just wasn't enough people to get to them." Another person said, "You can press the bell, and they will come, eventually." We spoke with one staff member who said, "We do our best to get there when they call but it's not always possible, depending on what else we are doing."

The manager told us they had completed a dependency assessment to establish the level of needs people had in St Audrey`s. From this assessment they determined they were not able to meet the needs of people due to the difficulties in recruitment and lack of permanent staff. They had developed a business plan which they had sent to the provider, which requested a suspension to new admissions to St Audrey's. In this review they had concluded that to provide care to people when the home was at full occupancy would require an additional 400 hours or the equivalent of ten additional care staff. Staffing rota's we looked at showed us that the assessed number of staff required for shifts was not always met, with staff working at lower

numbers than needed.

The manager told us that the current agency they worked with had proven unreliable in providing consistent care staff. On the day of our inspection the manager had completed a night shift to support the numbers of care staff. They told us they were working with a different agency in the interim to ensure they had the same workers block booked, meaning temporary staff would be able to get to know people's individual needs, as opposed to the constant changing of staff experienced recently. This demonstrated that although there were insufficient numbers of staff who provided consistent levels of care, the manager had assessed, reviewed and responded to this concern prior to our inspection; however the risk of unsafe care due to a lack of staffing remained.

People who required pressure relieving equipment to help maintain their skin integrity had their mattresses checked regularly to ensure they remained at the setting appropriate for the person's documented weight. Staff told us that people were assisted to reposition at appropriate intervals to help maintain their skin integrity and records were maintained to confirm when people had been assisted to reposition. However, staff had not assessed and documented the risk of people's skin breaking down routinely. Assessments for people who lacked mobility or who were at risk of developing pressure ulcers had not been carried out. Staff were aware of people who were at risk and people were referred to the district nursing team once they had developed a sore or had skin integrity concerns. However, the service offered by staff was reactive and not proactive in identifying this. The manager told us that the provider's policy was not to use an assessment tool such as a Waterlow assessment, which established the risk of people developing pressure ulcers. This meant that effective actions had not been taken to prevent the likelihood of a person developing pressure ulcers. This is an area that requires improvement to ensure staff are monitoring and assessing those people deemed to be at risk of developing pressure sores.

Staff were recruited following a robust recruitment process. People completed an application form, and had a minimum of two references. They also had a criminal records check in place prior to an offer of employment being made. Staff confirmed that checks had been applied for and obtained prior to commencing their employment with the service.

Requires Improvement

Is the service effective?

Our findings

People's mental capacity had not always been assessed for specific decisions regarding their care. Staff had not always established that people may have lacked capacity prior to providing them with care or support. For example, one person had a care plan and accompanying risk assessment completed for managing their challenging behaviour. The care plan contained a number of decisions that had been taken, and steps that could be used to mitigate the risk, however no mental capacity assessment or best interest multi-disciplinary meetings were completed prior to the care plan being implemented.

We also saw that mental capacity assessments were not in place for other decisions relating to people's care such as the use of bed rails. This meant that the requirements of the Mental Capacity Act (MCA) 2005 had not always been applied when considering people's ability to make decisions about their care or treatment. Not all staff were able to demonstrate a clear understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The management team had already identified this as an area in need of development.

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 DoLS. We checked whether the provider worked within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection the registered manager had identified people for who may be deprived of their liberty and had made applications to the local authority.

This was a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were positive about the food and menu choices provided at the home. One person told us, "The food is good, very good." A second person said, "[Person] sometimes has two dinners it's that good." One person's relative said, "You can have food 24 hours, round the clock, they never go hungry."

We observed people eating their breakfast and lunch. It was clear from the chatter and laughter at lunch time that mealtimes were relaxed and informal. People told us, and we saw that they could choose what to eat from a choice of freshly prepared food. Where people required support with eating their meal, staff assisted them sensitively, and provided them with equipment that supported their independence.

People were offered seconds after their lunch and dessert, and each person was offered a variety of different drinks. One person said, "I get up, come down, look at the paper, talk to my friends, I like a cup of tea, sometimes a cooked breakfast, other time some toast but I can have what I like when I like it really."

However, the experience for people who ate in their rooms was not as positive or sociable. Staff intermittently popped in and out to assist people, however on occasion when they left the person, their

meal was out of reach. Subsequently the food became cold and unpalatable and the person chose to no longer eat this. Their meal was removed, but no offer of reheating or replacing the meal was made and they were provided with their dessert. This meant that people who ate their meals alone in their rooms did not receive the required level of support to ensure their nutritional intake was sufficient.

People at risk of dehydration of malnutrition were quickly referred to the GP and dieticians, and the recommendations from these was followed. We saw that people had been prescribed supplements to aid weight gain and these were given to people regularly. A range of health professionals regularly visited the home, including two GP's and district nurses. One health care professional told us, "I think they care well for the residents here, I never had a concern and a member of staff is always available to assist me and my recommendations are always acted upon."

However, people's weights had not been routinely recorded as required. For example we saw for some people who were assessed as being at high risk of weight loss the weight for the previous month had not been completed. The manager told us that some of these people refused to be weighed. We asked the manager if they used other methods to measure people's weight, such as arm cuff circumference. They told us they did not. This meant that people's weights could not be accurately reviewed each month because they had not been routinely assessed, documented and reviewed. This placed people at risk of weight loss that may go unnoticed by staff.
However, when we asked staff about people who were at risk, they were able to tell us in detail about their current needs, level of risk, and how they managed their food and fluid needs. It was clear that people's dietary needs were reviewed among the staff team, however a formal assessment and review had not always been in place.
We recommend that additional methods of monitoring people's weight are considered, and that an accurate record is maintained in relation to people's weights.

People told us they thought the staff were sufficiently trained to provide care to them, however were less positive about agency staff. One person told us, "The regular girls are wonderfully capable, but some of the agency ones don't know how to do the simplest things." A second person said, "They [agency staff] don't know what I'm talking about so I have to show them."

Newly employed staff were required to complete an induction programme which included agency staff. During this induction staff had their competencies observed and assessed, and they shadowed an experienced staff member until they have demonstrated they had the necessary skills and confidence to work unsupervised.
Staff we spoke with told us they felt supported and received appropriate professional development by the management team. One staff member said, "[Manager] is approachable, I can talk to them about anything I need, and I often do."

We saw from the training records we looked at that staff training had been delivered in line with the providers policy, and staff were up to date. Training was provided in areas such as safeguarding, mental capacity, fire safety and medicines. In addition to mandatory training, staff were also provided with additional training to support them such as tissue viability, pressure care and dementia awareness. The registered manager had also arranged for the senior team to undergo supervision training to support the care team. One staff member said, "The supervision training is good because we will then be able to observe staff giving care and able to support them better." One senior staff member we spoke with told us prior to this training they did not really know what supervision meetings were for, however, they told us that after this training they felt prepared to offer guidance, support and development to staff.

We saw that the manager had also provided all staff with first aid, fire marshal training and a specialist 'Food First' dietary awareness course. The manager said, "I made it mandatory for all the staff to do this training because it is really important that all staff know how to respond in an emergency."

However not all staff felt they were developed in such a positive manner. Bank staff that we spoke with felt they were not given suitable opportunity to attend training, mainly because training was always on when they were not working. One bank staff member said, "I feel less comfortable around people with dementia and would like to have more training in this area."

We recommended that where bank staff were used to support people living at St Audrey's their training and development is provided in the same manner as regular staff members.

Requires Improvement

Is the service caring?

Our findings

When we arrived at St Audrey's, people were clean, well-groomed and dressed in clean clothing. However after lunch some people were left in clothing with food that had spilt over the front of them. One person was seen to have a white stain across their jumper for the remainder of the afternoon and a second person was observed to have a spillage across their blouse that was not cleaned.

People and their relatives had been fully involved in the planning and reviews of the care and support provided. We saw that for a person, the palliative nurse, their relative and the deputy manager held a discussion around planning future care and recording the person's lasting wishes. The views of the person were very much central to this discussion and together a plan of care was mutually agreed based upon the person`s views and wishes. We spoke to a person's relative who told us they had attended the home to review their relative`s end of life wishes. They said, "Relative is very well cared for which is weight of my mind, I now feel reassured the home had arranged a meeting with the specialist nurse." This person`s relative was pleased that they had been contacted to be able to support their relative when needing to discuss the difficult subject of future provision of palliative care, expectations and choices. After the meeting they said, "I now feel I can support [person] and am prepared for the worst."

However, in one person's care records we found that an assessment of capacity had been completed in relation to the person`s wish to refuse treatment. It had been documented that the person wished to refuse treatment, however no accompanying guidance was available like and end of life care plan. The manager was aware of the importance of this document and the impact it could have both for future medical treatment for ensuring this person`s final wishes were considered. Staff we spoke with told us that they felt less confident with caring for the dying and all felt they would benefit from end of life care training.

People told us they were treated with kindness and compassion by staff. One person told us, "The staff are very caring and kind people, they really do their best for us." A second person said, "It used to be a fantastic home, don't get me wrong, all the staff, regular or not do a great job, but we seem to have lost some of that personal touch we used to get."

We observed that staff had developed positive relationships with people, we saw constantly through our inspection that staff and people shared smiles, jokes and had meaningful conversations. People looked comfortable and at ease with the staff which promoted a relaxed and comfortable atmosphere within the home. We observed throughout the inspection that staff spoke to people in a respectful and friendly manner. People told us that at times some of the temporary staff did not know their name or particular needs. One person said, "The regular girls are wonderfully capable, but some of the agency ones don't know how to do the simplest things, or even who I am, they have to ask first."

Staff constantly ensured people's privacy and dignity was maintained. For example, we spoke with two people who were cared for in bed. When we asked staff to check if it was okay for us to speak to them, the staff members also ensured both were appropriately dressed and covered to maintain their dignity before they invited us in. Later in the day, we saw one staff member sensitively remove a person from the lounge to

assist them with personal care. They did this in a manner that did not alert others to their need and was very discreet.

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We observed throughout our inspection that staff were courteous and polite when seeking to assist people. Staff took their time to explain to people how they wished to support them and waited on each occasion for people to agree. When going into people's rooms to provide care, staff knocked and waited for the person to respond. We saw one carer knock on a person's door, and wait for a response. They were heard then to say, "[Person`s name] it's [Staff name] is it okay for me to come in, I need to help you get up for the day if that's okay?" They only opened the door and proceeded once the person agreed.

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People were encouraged and actively supported to develop and maintain relationships that were important to them, both at the home and with family and friends. People told us their visitors were free to come and go as they wished, and that no restrictions were placed on them about visiting family if they wished. One person said, "Of course I get visits, the family stay as long as they want to and if I choose to I can go to see them whenever I wish to." People told us that they had also developed friendships within St Audrey's that were important to them. One person said, "This is a lovely friendly special place, and I have made such good friends. It is like a little community all of our own."

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they felt staff listened to them and their views about their care mattered. One person said, "I say, they listen, they do." However people also told us that for those people who chose to stay in their rooms, there was very little interaction or stimulation.

We observed that activities were taking place in the lounge on the day of our inspection. A quiz had been arranged and those people who attended were enjoying the activity and the atmosphere was jovial and relaxed. We saw that on a notice board on the dining room wall, contained a large pictorial array of activities for people to participate in during the week and people were heard to be talking about them positively. One person said, "There's always something going on."

We found that for people cared for in bed, or who chose to not participate in communal activities, there was little engagement provided or any individual activity. Two people we spoke with told us that they at times felt lonely and isolated. One person said, "They [staff] walk past the door, they rarely come in to see me and the only contact I get is when I have some food, tablets or need some help, it makes me feel sad." A second person told us, "I feel lonely, I am no longer able to go along to the activities and staff are too busy to sit with me." The manager told us, "Activities is an area we need to develop, but until we have the restriction in place, then the staffing issues make it difficult, if I could just have a period of stability then I could address all of these concerns."

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that the staff involved them with developing a plan of support that addressed and managed their needs positively. For example one person living with complex needs had been assessed and reviewed with their relatives, the GP and staff from St Audrey's regarding their high levels of alcohol consumption which was detrimental to their health. Collectively they all arrived at a compromise that met this person`s needs, informed them of the risks and respected their wishes. However the reviewed plan of care also ensured that the outcome was safe for the resident and others in the home. This person was happy with how staff had supported them and felt that their views and opinions and views had been listened to.

However, assessments of people's needs were not consistently completed and at times contradicted the corresponding care plans. For example, we looked at one person's risk of falls. These had been recently reviewed and noted that the person was assessed as being both low and medium risk. This did not give a clear indication of how to support this person as there was contradiction is their assessed level of need. The family had requested to minimise the risk of a fall, that stair gates or door codes were used at the top of the stairs. However, the manager had dismissed these due to the likelihood of depriving others of their liberty. They had suggested moving the person to the ground floor, so the risk of walking down the stairs was removed, however this was declined by the family. As the person's risk assessments were unclear of how to support the person's needs, which had resulted in a subsequent accident, care plans and assessments were not responsive to people's needs.

A copy of the complaints policy was made available to people, relatives and visitors to St Audrey's. All the people we spoke with were aware of how to make a complaint and who they would address this to. People we spoke with told us that when they raised a concern or complaint, they had been satisfied with the outcome. One person told us, "I have raised concerns to the manager and I was listened to and the matter was quickly sorted out to my satisfaction." We saw examples of complaints that had been robustly investigated and the findings of these had been discussed with the person making the complaint. Where necessary and a complaint was upheld, actions were taken to address these. This meant that when complaints had been raised, the management team had responded to them appropriately.

Requires Improvement

Is the service well-led?

Our findings

There were no robust or effective systems in place to assess, monitor and review the quality of service provided. We looked at minutes from meetings and saw that staffing levels had been raised as a concern since March 2015. People had also raised concerns around the length of time that it had taken to answer call bells. Although both these issues were consistently raised as concerns these had not been addressed by the management team.

In October 2015 we saw that the manager had continued to provide regular forums for people, relatives and staff to provide them with feedback about the quality of service provided. We saw from minutes we looked at that the recently appointed Chief Executive for the provider had attended a meeting with both people and relatives. It was clear from these minutes that people views and opinions were sought, and areas for improvement centred on staffing levels, use of agency staff, and call bells ringing for long periods without being answered. We noted that the on-going issues remained as staffing levels and call bells response times were still an issue. The provider stated that call bells had been reviewed and there were plans to replace the system. We asked for a copy of a service improvement plan that detailed how and when new call bells would be installed or how they would be more robustly monitored. The manager provided us with an improvement plan for 2015 - 2016. This did not however clearly show how these areas would be improved and by when.

We looked at a copy of the improvement action plan that St Audrey's were working from. Numerous actions identified both at this inspection and also by Hertfordshire's commissioning team in a review carried out in June 2015 had been outstanding without a robust review. For example, one action regarding staffing was that, 'Weekend staffing levels are to be improved.' The reason for this was that weekend staffing was sometimes lower than required due to sickness. On 15 October 2015 this area was reviewed and simply noted as, 'Until full recruitment there will always be difficulties in ensuring staffing levels are acceptable at weekends.' There was no indicator of how staff would be recruited, by when, how many or when this would be next reviewed. The same ambivalent reviews were noted for the whole service action plan that gave us no reassurance that the registered manager had a well-developed plan and actions to deliver on the outstanding service improvements.

We also found that from the customer surveys received the registered manager had noted that the 'Residents need to feel more part of the local community.' However when they reviewed this action they noted, "There are always going to be problems with this whilst staffing and resident ratios are as they are. There is a need to look at all residents being asked what they want to do etc. to feel part of the community." Once again we found that action plans were ineffective, poorly reviewed and managed and did not seek to identify the root cause of how to overcome positively these issues.

Incidents and accidents had not been reviewed or assessed thoroughly. The manager had not received copies of accidents and incidents that staff had identified. Staff completed an incident form when a person had sustained an injury or there had been an untoward incident. However, when these were sent to the manager, the incorrect email address details were used in some examples. Where the manager did not review incidents regularly, they had not identified this until we prompted them to do so. This meant that

incidents had gone unreported, and the associated risks were not reviewed in people's care plans when needed.

When we looked at people's care records we found that these had not been reviewed for the previous month, or when their needs had changed. Where we have reported elsewhere in this report that care plans and assessments had not been developed, the manager had not identified this through their own individual audits of people's care records. When we reviewed people's records we found them to be out of date and asked the manager if they had been reviewed recently. They told us that the provider was due to install a new electronic system, which had been delayed. However they also told us that it was, "Quite likely if you look at all the care plans they will all be out of date."

This demonstrated to us, that although the provider and registered manager had sought to identify the concerns, they had not ensured there was not a robust and systematic method of reviewing, assessing and responding to concerns that affected the quality of service provided to people.

Records were incomplete, with a variety of care plans missing from people`s files that were pertinent to their care. For example, people at risk of developing pressure sores did not have an assessment of their need or a documented plan of care. Where the service employed a high number of agency staff, there was a substantial risk that without a documented care plan people may receive inappropriate care.

Daily records and observations of people throughout the day were not clear as the daily entries in care notes were not always completed. Incident reports we looked at had been completed but did not contain sufficient information to demonstrate how the incident happened and how the risk would be mitigated in the future. Risk assessments around concerns such as nutrition and weight management that were required had not been completed. Where these had been developed they had not been reviewed in the previous month as required by the providers policy. We found in numerous examples, that care plans had not been reviewed when changes to people health needs required them to be reviewed. This meant an accurate record of a person's care and treatment had not been maintained.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People we spoke with told us they felt the manager was, "Aloof and not always responsive." Staff we spoke with told us they felt the manager was approachable and listened to their views, although could be more visible on the floor. We were told by people and relatives that they did not feel the registered manager was as visible around the home as they should have been.

The manager told us that they operated an 'open door' policy and frequently met with family members to explore any concerns or compliments they had about the service provision. Relatives we spoke with told us that they were regularly asked to complete surveys and questionnaires about the quality of the service provided, and felt able to raise any issues with the provider. We looked at the results of the 2015 resident's survey. In this we saw that people felt they were safe, could choose when to get up and how to spend their day, and staff respected them and their belongings. We also saw that people felt that staffing was a concern with, "There are not enough permanent staff and too many agency staff," noted in the findings. People felt that there was not enough contact with the manager, that call bells took time to answer and, "A lot of staff have left the home, staff not as friendly and atmosphere not as relaxed as it used to be. Staff don't have time to chat or provide 1:1 stimulation." The manager had noted that call bells would be replaced as part of identified building improvement works that were due for repair in April 2016. However, due to the restriction being imposed, the provider told us that these works would be completed in the New Year. They said that

having the restriction in place would enable them to address many of the unresolved concerns, particularly in relation to staffing, call bell installation and documentation.

The provider had undertaken unannounced audits of the care received at St Audrey's. The Director of Operational Services had visited one day and remained there overnight. This was completed on 24 November 2015, and the concerns raised continued to be around issues such as call bell response times, being left on the toilet for long periods, and the large number of staff who had left. In addition staff raised concerns about rotas, and that they had only been completed on the Tuesday for the following week. They had identified this did not allow sufficient time to plan things such as private appointments for people. It was encouraging to see that some of the actions identified in the previous survey had been positively addressed. For example, staff had reported they were now receiving their allocated days off following the provider's previous visit. The results of this unannounced visit were then discussed with the management team and documented actions that would be taken forward. It was encouraging to see that even though the issues identified had been repetitive over a number of months, actions were being positively taken to address these concerns.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) (2) (b) People were not provided with the appropriate opportunities to ensure their identified social and community involvement needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (3) For people who lacked capacity to make their own decisions the requirements of the Mental Capacity Act had not been followed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) Medicines were not managed or administered in a safe manner to people.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) Systems and processes were not established and effectively operated to assess monitor and improve the quality of service people received, or that mitigated the risks to peoples health and welfare. Regulation 17 (1) (2) (c) An accurate record had not been maintained in relation to people's care and support needs.

The enforcement action we took:

Warning notice