Barchester Healthcare Homes Limited

High Habberley House

Inspection report

Habberley Road
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18 January 2018
22 January 2018
23 January 2018

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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

High Habberley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. High Habberley House accommodates up to 37 people across two floors. There were 17 people who were living at the home on the day of our visit.

This inspection took place on 18, 22 and 23 January 2018. The 18 January 2018 visit date was unannounced, which means the provider did not know we were coming. The 22 and 23 January 2018 we had arranged with the provider to return to the home to conclude our inspection visit. We found the service required improvement with five breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We were contacted by the provider a week after our inspection had finished. They notified us that a decision had been made to close the home. They told us this decision would be communicated with people who lived there and the staff who supported them.

Following the last inspection in July 2017, we asked the provider to complete an action plan to show what they would do and by when to improve in all of the key questions. This was because we found three breaches in regulation, for Regulation 9, Person-Centred Care, Regulation 10, Dignity and Respect and Regulation 17 Good Governance. At this inspection we found the provider continued to remain as Requires Improvement, with a continued breach of Regulation 9 Person-Centred Care, with further breaches in Regulation 12 Safe Care and Treatment, Regulation 17 Good Governance, Regulation 18 Staffing and Regulation 19 Fit and Proper Person's Employed.

There was a registered manager in place at the time of our inspection visit; however the registered manager was no longer working at the home and was in the process of de-registering with us. An operations manager had been managing the home for almost two weeks at the time of our visit. A new manager had been appointed who told us they would be applying to register with us.

A registered manager from the providers other service came to support the inspection visit. 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.

Staff recognised signs of abuse and knew how to report this. Risk assessments were not always completed properly, which meant that actions needed to keep people safe and minimise risks were not always identified and acted upon. People felt that more staff were needed to meet their needs in a timely way. The provider had recognised that further review of people's care was required as they could not be assured there was sufficient staffing to meet people's individual needs. People's medicines were managed in a way that kept people safe.

Staff supported people with their consent and agreement. However staff did not always understand the importance of this. We found that where Mental Capacity Assessments had taken place these were did not clearly demonstrate how staff were to support people, or whether other health care professionals had been involved in decision making around a person's care. We found people were supported to eat a healthy balanced diet and were given enough fluids to keep them healthy. We found that people had access to their doctor when they required them.

People told us that the provider had not listened to them, and they continued to receive care that was not always in line with their preferences. People told us that staff treated them kindly and respected their privacy. People told us that their wishes were not always met as staff did not always listen to them.

People did not always receive care that was reflective to their individual needs. Where people had specific individual needs, staff had not always recognised this to ensure their care reflected their personal preferences.

Information on how to raise complaints was provided to people, and people knew how to make a complaint if they needed to. We looked at the providers complaints over the last 12 months and found that two complaints had been received and responded to with satisfactory outcomes.

The provider had identified that their plans to improve the service were not on target, and had brought additional management resources in to support the service. The operations manager had been working at the home for less than two weeks prior to our visit. We saw the operations manager during that time had begun to make positive improvements to people's safety. However, throughout our inspection we found other areas of concern that had not been identified by the provider, however the provider responded to these concerns promptly. People and staff felt positive about the new general manager and while they recognised there was further hard work to do, staff felt positive this would improve with the new manager's support.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Identified risks to people were not always managed or responded to.

Staffing levels did not meet people's needs in a timely way,.

Staff recognised signs of abuse and how to report this. People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had the right skills to meet their personal care needs.

People received care that they had consented to; however assessments of people's capacity were not always clear for staff to follow.

People had access to healthcare professionals when they required these.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved or listened to.

People felt staff were kind and caring towards them and treated them with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff had not always identified people's individual needs and wishes, and because of this people's preferences were not being met.

People had opportunities to take part in interests and hobbies they enjoyed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had been through a period of instability in management, which had meant plans to improve the service delivery had not happened in a timely way.

The provider had recognised areas for improvement and had brought in an operations manager to promptly resolve the concerns. However, we identified further concerns during our inspection that the provider was not aware of.

The new manager was approachable to supportive to the people and the staff.

High Habberley House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18, 21 and 22 January 2018 and was unannounced. On the 18 January 2018 the inspection team consisted of two inspectors, a specialist advisor who specialises in governance 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. On the 21 and 22 January the inspection consisted of two inspectors.

As part of the inspection 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 by law. We also spoke with the local authority about information they held about the provider.

We spoke with nine people who used the service and two relatives. We spoke with three care staff, one nurse, one domestic staff, two activities co-ordinators, the receptionist and the chef. We also spoke with the general manager, the operations manager, area manager and the regional manager.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a sample of people's care records and medication records. We also looked at provider audits, complaints and compliments, incident and accident and the recruitment files of five nurses and three care staff.

Requires Improvement

Our findings

At the last inspection on 21 and 23 July 2017we rated this key question as Requires Improvement; this was because we found there were not sufficient staff with the right skill mix to support people. At this inspection we found the key question continued to be Requires Improvement. This was because people who were at risk of harm or injury had not had their needs fully assessed and reviewed, and the staff skill mix remained unsafe.

We spoke with people about how staff kept them safe, we received a mixed response from people about this, with one person saying, "Staff keep us safe by looking after us, never afraid." However other people shared examples with us about why they did not always feel safe. For example, one person told us they had to use an alternative bathroom that morning, due to urgent repair work in their bathroom, but it did not have suitable equipment to keep them safe, such as a raised toilet seat. They told us they had to shout for help until a domestic member of staff heard them and supported them. They told us they felt worried about their safety. Another person told us they had to wait a long period of time for staff to assist them and this did not always make them feel safe.

We looked at how people's individual risks had been assessed in a way that protected them from harm whilst promoting their independence. Our findings showed this was not always managed in a consistent way. For example, we saw staff used specialist equipment to mobilise a person from their armchair to a wheelchair. The person complained of pain and discomfort when staff transferred the person in this way. We spoke with staff who told us they worked with the equipment they had available to them. We looked at the person's care plan and saw that their mobility had been assessed which confirmed the person's mobility had deteriorated and they could no longer use the equipment we saw used and instead required an alternative piece of equipment to transfer safely.

During our inspection a staff member was visiting the home to carry out observations of staff practice. We spoke with this staff member who told us they had also witnessed unsafe manual handling practice for a further person and had reported this to the management team of the home. When we spoke with the management team they confirmed they had previously identified some people requiring different slings and were waiting for the order to arrive. They told us that in response to people's safety, these would now be urgently sourced to keep people safe from harm.

Identified risks to people's safety and well-being were not consistently carried out and applied so that the provider could be assured they were supporting people in the right way. For example, where people had

been assessed as being high risk of pressure damage to their skin, their assessments had not identified if they were using the right type of mattress or what pressure settings the mattress should be on for that person to reduce the likelihood of pressure damage to people's skin. Where people had wounds, their wound care records did not clearly demonstrate whether a person's wound was improving, or deteriorating further to understand if further treatment was required. We spoke with the operations manager who showed us that since their arrival they had implemented new records which detailed people's skin condition. This gave them a clear picture of people's skin integrity so that where action was required this could be done in a timely way. However at the time of our inspection people continued to be at risk due to waiting for the correct equipment to be sourced.

Most people we spoke with did not raise any concerns about how their medication was managed. However one person who was new to the service reported that their medication had not been managed well since their arrival. They shared examples of how their pain and warfarin medicine had not been managed and how this had impacted on them. For example, when they requested pain relief this was normally delayed. They told us they had brought in their own pain medication so they could take this in a timely way. We spoke with the operations manager about what the person had told us, who spoke with the person and worked with them to put better plans in place to manage their pain relief. We spoke with the person on the second day of our inspection who told us this was being better managed now.

Through speaking with staff and reviewing care records we found that staff did not always recognise potentially unsafe practice. For example, we read an incident record from October 2017 which described a person's sudden ill health; there was no record of medical attention being sought. We showed the incident record to the operations manager and regional director who told us they would have expected an emergency call to have been made and close on-going monitoring of the person's health. The regional director assured us that while this person no longer lived at this home, this incident would be reviewed for future learning of the staff team.

All of the above information demonstrates there was a breach in regulation which was Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safe care and treatment.

We reviewed the recruitment files for five nurses and three care staff. We found the provider's recruitment procedures were not effective to ensure staff employed to work at the service were safe to do so.

The provider did not have robust checks in place to ensure their nursing staff were on the Nursing and Midwifery Council Register (NMC). The NMC regulates nurses and midwives and set the standards for their training, conduct and performance. The provider's recruitment checks had not identified where employed nursing staff were working illegally. We raised our concern immediately with the provider, who took swift action to address the risk. The provider told us they were sharing their information with NMC so that appropriate action could be taken and would advise us of the outcome.

The above information demonstrates there was a breach in regulation which was Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Fit and proper persons employed.

We found that people continued to receive care that was not responsive to their needs. We also identified a further breach of Regulation 18 Staffing. This was because there were not always sufficient competent staff deployed within the service.

People we spoke with felt the staff did their best, but the service they received was to meet the needs of the staff and not the needs of people. One person we spoke with said, "When you press the alarm you can easily

wait 25 minutes for someone to come. Tuesday at 07:35 I used buzzer, a member of staff came, I'd not seen them before, and said to me, 'what are you pressing for?' They only just walked in and pressed buzzer off and went". A further person told us how they felt frustrated that they would ask staff for something and they would, "Disappear out of the door never to be seen again". A relative we spoke with told us, "It feels very under staffed here. I came to visit and [the person's name] had soiled themselves. Staff were busy, it was lunch time and we had to wait fifteen to twenty minutes for staff to come. I was quite upset about it, seeing [the person's name] like that".

We spoke with staff about whether they felt they were able to meet people's needs in a timely way. Staff said to us that it was difficult to support people promptly for a variety of reasons. Staff shared examples around the layout of the home and how this affected the care delivery. For example, 17 people lived in the home but in different areas throughout the home. They told us they would spend their time searching around the home for a second member of staff to assist them when someone required two staff for support. Staff also told us that the skill mix was not always well thought out. For example, newer staff working together, who did not fully know people's individual needs or how best to prioritise the support they could offer.

The operations manager and regional manager told us that they could not be assured there were sufficient staff to meet people's needs. The regional manager explained that through the quality checks that were in place they had identified that people's assessments of care had not been done to the providers expected standard. They said that without these accurate assessments they were unable to determine if people's dependency levels reflected the staffing levels. The operations manager told us they were addressing these areas of concern that had been identified. They told us they were also going to speak with people and offer them a choice of a different room, which would place people closer together so that staff were working closer together to support each other quicker.

The above information demonstrates there was a breach in regulation which was Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Staffing

People we spoke with felt staff kept them safe from harm. One person said, "Staff keep us safe by looking after us, I'm never afraid". We spoke with staff about how they protected people from abuse and they showed a good awareness of how they would protect people. Staff were aware of different types of abuse and what action they would take if needed. One staff member told us what action they took when they suspected harm and we saw actions had been taken. We found the operations manager had a good awareness of the safeguarding procedures and where they had identified potential concerns had worked with the local authority to ensure people were kept safe.

People and relatives did not raise any concerns about the cleanliness of the home. We saw the home was clean and tidy, and free from unpleasant odours. We spoke with a domestic staff who told us they had the equipment they required and enough time to keep the home clean. We saw the provider had systems in place to ensure infection control practice was being carried out, and where it had identified shortfalls for some staff and their hand washing, this had been addressed with individual staff. The service had not had any reportable infections or outbreaks, and the provider was aware of how they would report this to external agencies.

The operations manager had been working in the home for almost two weeks when we inspected the service. They told us that lesson's had been learnt to improve communication with the staff. Staff confirmed that regular meetings where now being held to improve practice. Staff told us that since this change they were able to support people in the morning sooner. Staff felt that communication was improving, and that they were able to learn from any matters raised to improve their practice.

Requires Improvement

Our findings

At the last inspection on 21 and 23 July 2017we rated this key question as Requires Improvement; this was because the provider had not ensured staff had the right support and training. At this inspection we found the key question continued to be Requires Improvement. This was because care assessments had not been adequately assessed and staff had not always been supported to develop their knowledge or have robust competency checks in place.

The provider had identified that people's care needs had not been adequately assessed to be assured that people were receiving the right care. The operations manager told us they were working through people's care assessments but they had only been supporting the home for almost two weeks and this was still an area for improvement. We saw examples where improvements to people's care and support had been made, however we found other examples where they had not. For example, one person had not been fully supported by staff to arrange a dentist visit. Due to this the person continued to remain on a soft diet. The operations manager spoke with the person and with their consent arranged for a dentist appointment. The operation manager told us, "There should have been someone advocating for [the person's name] and we have failed to do that".

People we spoke with felt most staff had the ability and knowledge to support them in the right way. One person said, "Most of staff appear to know what they are doing". However one person did not feel confident staff were able to support them with their specific care and treatment. Relatives we spoke with told us that staff were good and had no concerns. One relative who we spoke with told us "Overall care very good, nothing to say against it, staff very good".

Staff told us the training they had was computer based with some practical training, such as manual handling. One staff member told us they had asked for further training, but had not received any and felt they would benefit from further training. We were unable to ask any nurses about their training and competency checks, as the nurses who were working during the days of our inspection were not permanent members of staff to the home. The operations manager confirmed that nursing staff were checked for their competency in their role and said that any individual learning would be applied.

We spoke with two new members of staff who told us they had been observed in practice and had received good feedback. Staff we spoke with were able to relay information to us, such as keeping people safe from abuse and how the Mental Capacity Act 2005 may affect people's care. However newer staff did not have the full understanding of how this affected the way they supported a person when put into practice.

Care staff told us they carried out medicine counts with the nursing staff, however they were not clear why they were counting the medicine, or what they would do if the count was wrong. Staff had received basic induction training, however their competencies had not always been checked to deem them safe in their practice.

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 we spoke with told us that staff sought their agreement before carrying out any personal care and staff respected their wishes. People told us they had a choice and staff respected their wishes. During our inspection we saw one person fairly consistently requested to go outside. While staff did support the person to around the garden, staff we spoke with told us they could not let the person out alone as they were concerned for their safety. They told us this was because the garden was not enclosed and felt they were at risk of harm from the busy road outside of the homes grounds. We looked at the person's capacity assessment, to understand if this restriction was done so in-line with the mental capacity act. We could see that the assessment had deemed the person had capacity to make their own decisions about their care and wellbeing. We spoke with the operations manager about the person and whether they were being supported in the right way. The operations manager felt the staff were acting in the person's best interest and supported the person in the least restrictive way to keep them safe from harm. They explained that they had identified some people's capacity assessments required further work to ensure they were completed correctly so that people were being supported in line with their best interest.

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

The provider had sent CQC notification's to confirm that two people who lived at the home had a DoLS in place. However staff we spoke with were not aware of who had a DoLS in place and how this may affect their care. The operations manager explained they would ensure staff were updated with this knowledge.

People who we spoke with told us they enjoyed the food at the home. One person said, "Food is good and of course a choice, whatever you want, they will do it for you. I had poached eggs today". Another person said, "Food pretty good here". People told us staff ensured they had enough to eat and if they were happy with their meal. On the first day of our inspection we did see people who were nursed in bed where given their meals at the same time, however staff were not available to assist them with eating their meals which meant that we saw some meals left to go cold before a staff member could assist them. We spoke with the operations manager about how long people were waiting for assistance, who discussed with staff about a better way to support people in their rooms at meal times. The following two days of our inspection we saw staff only took meals to people when they were available to support them. Staff we spoke with told us this was working well.

We saw people were offered hot and cold drinks throughout the day and staff ensured people had drinks to hand. People confirmed staff offered them enough to drink throughout the day. We spoke with staff about what steps they took to ensure people received adequate fluids. Staff knew who was at risk of de-hydration and the importance of recording how much fluid people had drank. A staff member told us it was so that

checks could be made to ensure people were drinking enough fluids to keep them healthy. We spoke with the chef who advised they had regular meetings with the nurse to understand who required a specialised diet, and who needed further calories due to weight loss. They told us that this usually happened regularly, but over the last few weeks they had not happened. The operations manager confirmed that this was due to the change in management, but the meetings had been re-scheduled to keep the chef updated and the chef confirmed this.

People we spoke with told us they had access to a doctor if they needed one. One person told us that when they had become ill, staff had contacted the doctor who prescribed them medicine. They told us that staff were aware of this and provided them the medicine. However for routine appointments such as visiting the dentist, optician or chiropody care had not been consistent. The operations manager was aware of this and was putting plans in place to ensure people were up to date with their routine health care appointments.

A relative told us that staff always informed them if their family member had become unwell and needed the doctor or hospital treatment. Staff shared examples of who they would contact if a person became unwell and felt confident people would receive the right support.

The home was warm and people said they felt comfortable in the home environment. The communal areas were homely and inviting for people. The communal areas had enough space for people to be able to freely move around. Where people invited us into their bedroom's we noted they were well maintained. One person told us that when the hot water had stopped working in their bedroom this was fixed immediately. The general manager told us some bedrooms had a toilet and sink, while other bedrooms had just a sink. All the bathrooms and shower rooms were for communal use. One of the bathroom's on the ground floor was out of use and was awaiting repair. There was a further bathroom on the ground floor and a bathroom and shower on the first floor which were in working order. People had access to the garden areas, however during our visit people told us they preferred to stay indoors during the cold weather. Where a person did want to go out, staff supported the person to do this.

Requires Improvement

Our findings

At the last inspection on 21 and 23 July 2017 we rated this key question as Requires Improvement; this was because there were inconsistencies in staff's knowledge of people's needs and people were not always treated with dignity and respect. We found the provider failing to meet Regulation 10, Dignity and Respect. At this inspection we found the key question continued to be Requires Improvement. While we had seen improvements around treating people with dignity and respect, and the provider was now meeting Regulation 10, there remained inconsistencies with involving people in decisions around their care.

People had previously raised concerns about how staff did not support them with their personal care in the way in which they would prefer. They also continued to raise concerns with us about staff's timeliness to respond to their requests. People expressed their frustrations with us that they did not feel listened to. While we saw staff were caring through their interactions. People had not been properly supported by the provider to effectively change the culture within the service, so that improvements to care could be made.

We saw throughout our visit staff were kind and caring towards the people they cared for. All people we spoke with felt staff supported them in a kind and caring way. One person told us, "The staff are very good". Relatives we spoke with were complimentary about the staff who supported their family member. People were supported and encouraged to maintain relationships with their friends and family. A visiting family member told us they visited regularly and were made to feel welcome.

We saw positive interactions between people and staff. One person told us about the activities co-ordinator who worked between the providers two homes and said, "We like [the activities co-ordinator] we want them to come back. The atmosphere here today is wonderful isn't it, so different to what it has been before". Over the three days of our inspection visit we saw people and staff chatting, smiling and laughing with each other. Staff told us who enjoyed the banter and we saw that people enjoyed this. Other people preferred a quieter environment and we saw staff also acknowledged and respected this, and would spend time sitting with people having quiet conversations about their day and how they were feeling.

People had the choice to stay in their room or use the communal areas if they wanted to. People told us they chose their clothes and got to dress in their preferred style. We saw staff support a person to maintain their dignity and offered gentle support to the person. We saw staff knocked on people's bedroom or bathrooms doors and waited for a reply before they entered. We saw staff took their time with people whilst they were supporting them, such as supporting a person to eat their meal at their own pace, or linking arms with the person to assist them down the corridor. Staff spoke respectfully about people when they were

having discussions with other staff members about any care needs.

Requires Improvement

Our findings

At the last inspection on 21 and 23 July 2017 we rated this key question as Requires Improvement and found that the provider was failing to meet Regulation 9, Person-Centred Care. This was because people were not supported to have their individual needs met. At this inspection we found the key question continued to be Requires Improvement with a continued breach of Regulation 9, Person-Centred Care.

People told us that decisions they made about their care did not always happen. For example, people's preferences, such as what time they got up in the morning and what time they went to bed. We spoke with people to understand how the provider met their needs and understood their preferences. People we spoke with who were dependant on staff support to get up in the morning and go to bed told us they did not always have a choice when this happened. One person said, "I'm up at the crack of dawn, as soon as the sun comes up. It's like being back in the army". They continued to say, "I go to bed when they put me to bed". We asked if they had the opportunity for a lie in, and they said, "If you want a lie in your left in bed for the rest of the day. It's their way of getting out of washing me".

A further person told us they were trying to remain as independent as possible in all aspects of their personal care. However they were unaware of the washing facilities available to them, such as showers, which they felt would have maintained their independence with their personal care. They told us that as they required two staff to support them with a bath and staff did not offer to support them. We asked the person if they had asked staff for support. They told us they had "Given up asking" and continued to say "I wash myself down at their hand basin". We did raise this concern with the operations manager so that this person could be better supported with their personal care.

We explained to the regional director and operations manager what people had told us. They agreed that people's care was to be discussed with the person, so that they could fully understand their wishes and preferences. They advised that the operations manager would be addressing this, with plans to review each person's care to ensure their needs were being met.

All of the above information demonstrates there was a continued breach in regulation which was Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Person-Centred Care

We asked people if they had the opportunity to discuss their hobbies and interest with the staff so they had a better understanding of their likes and dislikes. People told us that some activities did take place, which they enjoyed. People spoke of their pen pals, where they would receive letters from children at a local

school and would write back to them. One person told us that the children came to visit them and they had enjoyed this. Other activities took place, such as flower arranging or board games. We saw a positive interaction with one activities co-ordinator who spent time with people and talking about their interests. We saw how this engaged people in a natural conversation when this approach was taken. People told us that the atmosphere the activities coordinators brought was very good, and they appreciated the work they had done as it, "Lifted people's spirits".

The provider shared information with people about how to raise a complaint about the service provision. This information gave people who used the service details about expectations around how and when the complaint would be responded to, along with details for external agencies were they not satisfied with the outcome. We looked at the provider's complaints over the last 12 months and saw two complaints had been received. The concerns were around the timeliness of staff supporting a person with their personal care and staff not offering regular baths. These complaints had been responded to by the provider and we could see the complainant was satisfied with an apology. However, we continued to find that people did not receive the support for regular baths and people continued to raise concerns about the timeliness of staff support. Therefore the provider had not demonstrated they had learnt from these complaints and reduce the likelihood of the complaint from happening again.

Requires Improvement

Our findings

At the last inspection on 21 and 23 July 2017we rated this key question as Inadequate and gave the provider a breach of Regulation 17 Good Governance, this was because the provider did not have effective systems to monitor the quality and safety of care people received to make the necessary improvements. At this inspection, we found the key question had improved to Require Improvement, this was because the provider had identified through their own systems and checks areas that required improvement and had put plans in place to address these. However, there had been a period of management instability and more time was required to understand if the provider was adequately supporting the home management team. At this inspection, we found the provider was now meeting the Regulation 17 Good governance.

The service had been through a period of instability with the management team since the last inspection. This had had a negative effect on the timeliness of actions being taken to drive the improvement required. At the time of our inspection there was a registered manager in post. However, they were no longer working at the home and were in the process of de-registering with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider was aware through their own checks and audits that the service was not performing as expected. We saw the provider's audit in November 2017 highlighted areas for improvement remained. For example, care planning and assessment, along with improvement of staff's knowledge and safe practice. A further provider audit on 4 January 2018 took place which showed that improvements were still required. The regional director told us that the service required additional support and on the 8 January 2018 an operations manager came to support the management team.

We saw evidence that the operations manager had begun taking prompt action to ensure people were safe and were receiving the right support. For example, people had had their skin integrity assessed to ensure anyone with sore skin had the right treatment in place. In addition people were having weekly weights to ensure any weight loss was recorded so further action could be taken. The operations manager was aware of the wider concerns and was working on resolving these. Where we raised our concerns on the first day, the operations manager had reviewed these and had discussed them with people and staff. They had put clear records in place to further support their actions.

We spoke with the regional director about the providers system for raising concerns promptly going forward.

They explained that the system was only as good as the information entered into it and had recognised this was reliant managers being fully aware of the Barchester systems and procedures and the support and resources available to them. During our inspection we met a new general manager. They told us they had worked for Barchester for many years and were knowledgeable of the systems and resources available to them.

We saw the new general manager interacted with people who lived in the home. This was done in a friendly way. People we spoke with told us they liked the new general manager. We saw they were visible within the home, listened and supported people. We saw them introducing themselves to visitors and offering them the opportunity to meet with them in the office to discuss any aspect of the service. Some of the staff we spoke with had worked with the new general manager before. One staff member said, "It's very re-assuring to have [general manager's name] here. They are very approachable and around on the floor". Staff felt that with stable leadership in place the service would improve. One staff member said, "There is a lot of hard work to be done here, but with the right leadership now, it will be okay".

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's care and treatment was not always assessed to meet their needs and preferences. People were not enabled to make their own decisions about their care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People did not always receive safe care and treatment because their care and risk assessments did not consistently identify risk. Staff did not always have the skills and competency to meet people's needs safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
	The systems and processes the provider had in place were not always effective to ensure people received safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care Treatment of disease, disorder or injury	proper persons employed Recruitment check were not effective. Checks to professional body registrations were not made to ensure the staff who worked at the home were doing so in a legal way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient, suitably qualified staff to meet people's needs.