European Care (GB) Limited

Sydmar Lodge

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This unannounced inspection took place on 18 November 2014. Sydmar Lodge provides accommodation and personal care services for up to 57 people. Its services focus mainly on caring for older people including people with dementia. There were 42 people living in the service at the time of our inspection.

We last inspected this service in May 2014 at which we found no breaches of regulations. However, we decided to inspect the service again as a result of information we received since then. This included changes of manager at the service and outcomes of safeguarding investigations.

There was no registered manager in post at the time of our visit, however, a new manager was working at the service and had started the process of applying for registration 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.

At this inspection, we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

We found that people were not being protected against the risks associated with the unsafe use and management of medicines. This was because we found occasions when people had not been given their medicines as prescribed.

We found that, where people needed support with eating and drinking, they were not protected from the risks of malnutrition and dehydration. The monitoring of people's weight was not taking place regularly. Whilst we saw some people enjoying lunch, sufficient attention was not paid to those with greater support needs.

We found that the planning and delivery of care was not consistently meeting people's needs and ensuring their welfare and safety. We found instances where care plans did not reflect the changed needs of some people, which put them at risk of receiving inappropriate or unsafe care, particularly because of ineffective communication between staff and the use of a number of different agency staff.

We found that two people's call-bells were not set up to call for staff assistance. One had been identified for repair six weeks earlier but this had not occurred at the time of our visit, which was compromising their safety and welfare.

We found occasions when there were not as many care staff working as the provider planned for. This affected the delivery of care and support to people. We saw instances where people had to wait, such as for support to use the toilet. We were not assured that there were enough staff available at all times, to keep people safe. However, people's feedback and our observations of how staff interacted with people showed that staff were patient, kind and caring towards them.

Concerns around people sometimes having to wait for staff support had been raised in meetings for people using the service and their representatives three months before our visit, however, we found that these concerns had not been responded to effectively and that people still experienced waiting for staff support.

The provider did not give us specific details of recent complaints and responses when requested, and the complaints procedure was not on display in the service, which did not assure us of an effective and well-organised complaints system.

The provider's quality team had recently identified a number of concerns about how the service was protecting people against the risks of inappropriate or unsafe care, however, actions arising from this had not addressed concerns effectively. We also identified shortfalls in the effectiveness of other quality auditing processes used by the provider, including for complaints processes.

We found that the provider's systems of ensuring that the service enabled people to consent to care and treatment in line with legislation and guidance had not been effectively implemented.

We found that whilst staff were given training to help ensure that they had the skills and knowledge to provided effective care, there had been little staff supervision in recent months. This did not assure us that systems of supporting and guiding staff on how to meet people's needs were effective.

The provider did not keep us informed of changes to the management of the service, which did not assure us that when there were significant changes to the service, the quality and safety of the service would be maintained, which our overall findings confirmed.

Summary of findings

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. We found occasions when people had not been given their medicines as prescribed. This may have had an impact on people's health and welfare.

Many people told us that they sometimes had to wait for staff support. We found occasions when there were not as many care staff working as the provider planned for, and we saw that people sometimes had to wait to when requesting staff support. We also found that two people's call-bells were not set up to call for staff assistance. This affected the delivery of care and support to people.

Some safety checks in the service had not taken place in line with the provider's expectations. We also found that recommendations of specific risk assessments for some people had not been acted on. This may have compromised people's safety and welfare.

The service had systems in place to protect people from the risk of abuse and to take action when allegations of abuse occurred.

Is the service effective?

Inadequate

The service was not effective. We found that where some people needed support from staff with eating and drinking enough to meet their needs, they were at risk of malnutrition and dehydration. The monitoring of people's weight had not taken place in line with the provider's expectations, and whilst we saw some people enjoying lunch, sufficient attention was not paid to those with greater support needs.

We did not come across anyone who we considered to be at risk of unauthorised deprivation of their liberty. However, the provider's systems of ensuring that the service enabled people to consent to care and treatment in line with legislation and guidance had not been effectively implemented.

We found that whilst staff were given training to help ensure that they had the skills and knowledge to provided effective care, there had been little staff supervision in recent months. This did not assure us that systems of supporting and guiding staff on how to meet people's needs were effective.

There was evidence of attention to people's healthcare needs, including through liaison with community healthcare professionals.

Is the service caring?

Good

The service was caring. People's feedback and our observations of how staff interacted with people showed that staff were patient, kind and respectful towards people using the service.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people. Concerns around people sometimes having to wait for staff support had been previously raised, however, we found that these concerns had not been responded to effectively and that people still experienced waiting for staff support.

The provider did not give us specific details of recent complaints and responses when requested, and the complaints procedure was not on display in the service. This did not assure us of an effective and well-organised complaints system.

Care plans were kept up-to-date, however, we found instances where they did not reflect the changed needs of some people, which put people at risk of receiving inappropriate or unsafe care.

The service provided people with a range of activities throughout the day, and supported some people to access the community for events that they enjoyed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. There had been two changes of manager during the year. Although a senior manager had been recently based at the service to provide additional support and consistency along with a new manager, the provider did not keep us informed of changes to the management of the service, which did not assure us that when there were significant changes to the service, the quality and safety of the service would be maintained.

The provider audited the quality of many aspects of the service in August 2014 and identified a number of improvements needed. Whilst some of these had been addressed within the timescales set, others had not, and we found that this had an ongoing impact on people's safety and welfare. We also identified shortfalls in the effectiveness of other quality auditing processes used by the provider, which may have put people at risk of inappropriate or unsafe care.

Sydmar Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 November 2014 and was unannounced. The inspection team included two inspectors 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.

Before the inspection, we reviewed the information we held about the service. This included notifications the provider sent us about significant events at the service, and records of safeguarding meetings involving people using the service that the local authority had sent us. We did not ask the provider to send us specific information in advance of this inspection.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care in the communal areas such as the lounge and dining area and met some people in their rooms. 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 used the information we gathered to track that the care people experienced matched what was planned in their records ('pathway tracking').

We were told that there were 42 people using the service at the time of our visit. We spoke with 25 people who were using the service and four relatives. We interviewed members of the management team and seven staff members. We looked at four people's care records, eight staff files, duty rosters, and various records used for the purpose of managing the service.

The service's new manager was not present during our visit.

Inadequate

Is the service safe?

Our findings

People told us they felt safe using the service. However, when asked if there were enough staff working or if there were times when they had to wait for staff to provide support, 14 people responded negatively and only three positively. People's comments included, "They're short staffed, you do have to wait unless it's urgent", "They need more staff, especially mornings", "Sometimes they've not got the staff, for example, if you want the toilet" and "There used to be six night nurses, now there are only three or four for the whole building. How can they manage with that? In the evenings, there is hardly anyone on this floor, they do the medication and then leave."

At 8:15am, we heard someone shouting for staff support from their room on the first floor. We found the person dressed, in their bed and dependent on staff support to get up. When we asked about their call-bell, they said, "I don't have one." We sought staff support for this person, although it took a further fifteen minutes before the two staff members needed to assist this person were available. We later established that the call-bell had been identified as faulty during a check six weeks earlier, however, it was yet to be fixed. The planning and delivery of care to this person was not meeting their needs or ensuring their welfare and safety.

At 5:40pm, we heard someone shouting in their room on the second floor. We found the person to be dressed, under covers in bed, and the room to be noticeably warm. We found their call-bell to be on the floor behind their bed, meaning it was inaccessible. When we rang the bell, it took seven minutes before a staff member attended. We then had to let them into the corridor, as they could not input the correct code to gain access. When we discussed this with the management team, they told us this person had been taken to their room for a couple of hours as they were falling asleep at lunch. They confirmed this person was ordinarily able to operate their call bell. The planning and delivery of care to this person was not ensuring their welfare and safety.

The management team told us that the expectation was for call-bells to be answered within three minutes. They were aware that the current equipment did not enable retrospective checks of the promptness of responses to people, and told us that there were imminent plans to install a new system that would allow this.

We saw two occasions during our visit when it took much longer than expected for the call-bell to be answered. During a morning reminiscence session, one person asked for support to use the toilet. The staff member running the session rang the call-bell for assistance, but after ten minutes no-one came to help. Administrative staff were asked to search for care staff. We also heard the call-bell ringing for one person for at least 14 minutes, at around 11am. When we checked with this person, they told us they wanted a drink. We found staff to provide support. Shortly afterwards, we found three of the seven care staff taking a planned break. The time taken to respond to call bells did not assure us that the planning and delivery of care to people was meeting their needs and ensuring their welfare and safety.

Two people told us they did not always get their medicines on time. One person said that they had had to "ring the bell to remind staff to give me my antibiotics once or twice." During our visit, we saw someone being given morning medicines at 11am. Staff provided people with medicines support in a safe and unhurried manner, however, we were concerned that people's welfare may be compromised if receiving some medicines much later than the prescribing instructions.

We noted two instances where we came across people who had degrees of dementia and were looking for their rooms. Along with corridors and doors looking very similar, which did not help to orientate people, there were no staff immediately available to assist them. This matched someone's feedback to us about the service being short-staffed, which they felt did not impact on them, but did for people who had dementia. The planning and delivery of care to these people was not ensuring their welfare and safety.

The service was using a staffing tool that measured the dependency of each person to clarify the number of care staff needed per shift. The management team told us that care staffing levels were seven staff in the morning, five in the afternoon and four at night.

We checked the roster, staff attendance records, and records of agency staff used for the first two full weeks of November. Whilst additional staff had been provided at night relative to the required staffing levels, there were six occasions when there had been only six staff rostered to provide care in the morning. This coincided with some staff switching to night work, and some staff not attending

planned shifts, although the records provided to us did not clarify reasons for this. We were not assured of effective planning and delivery of care to meet people's needs and ensure their health and welfare.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Three people and a relative told us staff changes had an impact on the care they received. One person said, "The new night nurses do not stick their heads around the door when they come on shift." Two people referred to the use of agency staff at the service, commenting, "They don't know you," and "There is a difference in the quality of care." We noted that at our last inspection in May 2014, we reported that the service was not using agency staff, meaning that there had been some turnover of employees since that inspection.

We checked which agency staff had worked in the service providing care to people across previous weeks. The records showed us that 16 different agency staff members had covered 54 care shifts in the last month. This did not demonstrate continuity of staff, as there were few agency staff who were being provided with regular shifts to help them become familiar with the people they were providing care for. This did not assure us that the care and support people received was consistent and safe.

We checked the service's arrangements and management of people's looked-after medicines. We found that prescribed medicines had run out for three people recently, and so they had missed prescribed doses. For example, one person's medicine administration records (MAR) indicated that the stock of one prescribed medicine ran out a week before our visit, and so they were not able to take this medicine on three occasions across two subsequent days. The current box of this medicine had a prescription label with a date that matched when the person started receiving the medicine again on the MAR. The person could have been at risk of an exacerbation of their condition due to this medicine running out.

When we checked for the medicines listed on the current MAR for another person, we could not find any stock of two of their prescribed medicines. One medicine was prescribed for nightly administration, but the MAR recorded that further stock was needed the night before our inspection. The other was a medicine prescribed for as-needed administration, for which there was an entry on the MAR indicating that there was no remaining stock over a week beforehand. Before we left the service, a member of the management team told us that there had now been a delivery of this person's medicines. However, we were not assured that appropriate arrangements had been made for the obtaining and administering of medicines for this person.

Our checks for this person also found that they were administered five less tablets than prescribed for once daily-administration of two tablets of a medicine across the eight days up to our inspection visit. This may have affected their response to the treatment prescribed.

Our checks for another person raised concerns that they were administered five extra capsules of medicine prescribed for a variable daily dose, across the nine days up to and including the day of our visit. This put the person at increased risk of side effects.

Overall, we checked the MAR against stock for 18 separately-packaged medicines of 12 people. We found a discrepancy between the remaining stock, administration records, and the stock recorded at the start of the MAR, or evidence of missed administrations, in nine cases. This showed that people may not have been receiving their medicines as prescribed.

We saw administration gaps in the current MAR for four people. For one person, this included for all medicines at 10pm on two specific days. When we checked two boxed medicines for this person against the MAR, we found no discrepancies, which indicated that the gaps meant that person did not receive those medicines as prescribed on those days. This did not assure us of that appropriate arrangements had been made for the using and safe administration of medicines.

One person was prescribed a pain relief patch for weekly administration according to records in the controlled drug register. There was no entry for the week before our visit, with no explanation in the register. Remaining stock of the patch indicated that the patch had not been administered. We discussed this with the management team. They looked into this, and told us after the inspection visit that a GP review had taken place with instruction for the patch to be discontinued. However, they began investigating why it was then administered on one occasion contrary to GP

instructions. The person did not receive this medicine as prescribed, which did not assure us of that appropriate arrangements had been made for the recording, using, and safe administration of medicines.

The above issues are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted that the service provided some aspects of safe medicines management despite our concerns above. Medicines were stored securely, and we found no out-of-date medicines. Medicines were kept at correct temperatures, and monitoring of this took place. We saw also medicines being given to people in a safe and respectful manner. For example, staff sat with people to support them to take medicines when needed. They ensured that people had a drink to take the medicines with.

There were processes in support of keeping people safe. We saw individualised personal emergency evacuation plans had been recently written in response to foreseeable emergencies. Individual risk assessments were in place for people to help protect them from harm, for example, for prevention of falls, safe manual handling, and the use of bedrails. These had been recently updated to reflect people's current circumstances.

We found safety certificates in place for equipment and premises maintenance, for example, for the fire equipment and for testing water supplies against the risk of Legionella. Portable electrical appliance testing was ongoing at the time of our visit. However, when we looked at records of employee checks of the premises that were recorded as requiring at least a monthly frequency, we found that these had not been kept up-to-date. For example, the last recorded dates of the checks of the fire door closures, fire escape routes, and maintenance checks of wheelchairs and window restrictors, were over two months before our visit. The management team told us that the service's maintenance worker, who was responsible for these checks, had recently left and a new worker was to start work shortly. However, arrangements had not been made for someone to make the checks in the interim period, which did not assure us that foreseeable risks to people's safety were being identified.

We saw an action plan from a health and safety audit dated two weeks before our visit. It identified a number of improvements required for the safety of the premises. We noted that one point for immediate action was "all fire safety checks must be completed at the correct intervals and all checks must be recorded." That had not yet taken place for the fire door closures and fire escape routes according to our findings, which put people in the premises at unnecessary risk to their health, safety and welfare.

The above issues are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had a safeguarding policy available in the service. It recognised types of abuse, expectations to report concerns, and how the service would work in co-operation with external agencies. Our information from the local safeguarding team indicated that the service was following its policy expectations of reporting safeguarding concerns and working together to minimise the risk of abuse.

Training records indicated most staff had received recent training on safeguarding processes, and that the management team monitored this. Staff we spoke with understood how to safeguard people they supported and raise concerns if needed. They confirmed awareness of the provider's whistleblowing policy. Whistleblowing guidelines were on display in the service, in line with the safeguarding policy expectations. This helped ensure that staff knew how to raise concerns about people's treatment if needed.

Inadequate

Is the service effective?

Our findings

Most people we spoke with made positive comments about the food and drink provided. Comments included, "It's excellent", "It's good quality" and "It's 100% Kosher." The feedback from a few people was that the quality and choices could be improved on. We saw that the service had recently consulted with people about food and drink arrangements and was making plans for improvements. We also saw evidence of trying to meet people's specific meal requests.

However, when we checked that people received the support needed to enable them to eat and drink enough, and that people with greater support needs were provided with meaningful food choices, we found that the service was not protecting people from the risks of inadequate nutrition and dehydration.

One person's recent hospital discharge records referred to the service needing to ensure adequate fluid intake. However, we found no specific fluid monitoring records for this person. A member of the management team confirmed that fluid charts were ordinarily set up when risk was identified, which should have occurred for this person. The service sent us documentation after the inspection to demonstrate that the charts had now been set up. However, until we pointed this out, the service had not been protecting this person from the risks of dehydration.

We saw during lunch that the same person did not receive any support from staff with eating and drinking. We saw that they ate approximately a quarter of the main meal before pushing it away. When we spoke with this person, they told us that they had not had dentures available for six weeks. Staff told us that a dental appointment had been made for this person. In light of the person needing dentures in place to assist with eating, we were concerned that they were not provided with the support needed to eat sufficient amounts to meet their needs.

We saw at lunch another person using only a fork in one hand to move food from the plate to their mouth. This sometimes resulted in them pushing food onto their lap. After the meal, we saw that a lot of food had ended up on their weaker arm. A member of the management team told us that there were plate guards available that could have been used for this person. However, none were provided to this person during lunch, and we did not see any staff interaction with this person to support or assist them to eat. This did not protect them from the risks of inadequate nutrition.

During the morning, we saw someone tell a staff member that a glass cup was too heavy for them to handle alone. The staff member supported them to drink from the cup. At lunch we saw the person given the glass cup to drink from again, which they did not do, and for which staff provided no support. We also overheard staff asking where lids were for the spouted cup that the person drank soup from at lunch. No lid was ultimately supplied. The support provided to this person did not protect them from the risks of malnutrition and dehydration

We checked the folder used at the service to record and monitor people's weights. It showed that, with a few exceptions, people had not been weighed since mid-September, a period of two months. We also looked at the Malnutrition Universal Screening Tool (MUST) nutritional assessment in the files of four people. These were last reviewed in September 2014 despite the process prompting for monthly review, which the management team explained was because of the delay in weighing people.

We checked the provider's action plan dated October 2014 in response to their whole-service audit of August 2014. It identified that MUST assessments needed to be undertaken every month, to identify people's changed nutritional needs and update care plans as needed. The target date for this was a few days before our inspection visit, however, the MUST updates had not taken place. This did not assure us that people were being protected from the risks of inadequate nutrition and dehydration through support, where necessary, to eat and drink sufficient amounts for their needs.

The service is listed on our website as having dementia as a service specialism. We found there was little provision to enable people with dementia to choose food that they liked. There were no menus available, and no picture representations of food, despite this being highlighted as a service shortfall within the provider's whole-service audit of August 2014. During our observations of lunch, we saw no evidence of plated meals being shown to people to enable them to make a choice of which meal to have. We saw that some people were asked which of the available meals from the serving trolleys they wanted to eat, however, we also

Is the service effective?

saw two instances where this did not occur. We were not assured that people were protected from the risks of inadequate nutrition and dehydration, through the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet their needs.

The above issues are a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection the management team told us there were no DoLS authorisations in place and no applications had been submitted for people currently using the service. We did not come across anyone who we considered to be at risk of unauthorised deprivation of their liberty.

The provider had a Mental Capacity policy that covered many aspects of their responsibilities under the Mental Capacity Act 2005. This included training staff to be aware of their individual responsibilities and how the Act protected them if it was followed appropriately in their work with people using the service. When we spoke with staff about this, they placed emphasis on the respect of people using the service, enabling choice, and on no-one being restrained. They did not show awareness that, for example, where people used bed-rails to help prevent falls from their bed, this was an acceptable form of restraint if guidance from the Mental Capacity Act had been followed. We noted that where people had bed-rails in place, assessments had been written. However, within people's files we found no capacity assessments relating to the restriction placed on people by having key-codes used to exit corridors or the front door.

A member of the management team told us that where considered safe, people were provided with the key codes to enable individual access, and so some people could come and go from the service if they wanted to. However, they confirmed that capacity assessments beyond bed-rails needed to be done to meet the requirements of the Mental Capacity Act 2005, as identified in the provider's whole-service audit of August 2014. When we asked to be shown any evidence of capacity assessments that deduced the person did not have capacity to consent to a particular care decision, or any evidence of best interest meetings, none was supplied. This did not assure us that consent to care and treatment was always sought in line with guidance and legislation.

The above issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A range of online training was made available to staff of all roles, and was supplemented by some face-to-face training courses. Staff told us they were happy with the training provided. A new staff member told us they received a week of induction training before providing care to people, which equipped them to do their job. Training records showed that most staff had passed assessments to demonstrate training covering a range of topics. The provider's training system reminded staff and the management team to update training after fixed periods of time. The management team told us that systems of checking staff competency were about to be implemented at the time of our inspection, including for medicines administration.

When we checked records of six staff members who had been working recently, we found supervision records that provided them with support and guidance to carry out their roles of providing care to people. However, the last recorded supervision dates were six months ago, despite next sessions being booked for within two months in line with the provider's policy. The provider's whole-service audit in August identified inconsistencies with staff supervision frequency and made plans to address this. However, we found that no action had taken place as planned. We were not assured that there were suitable arrangements to ensure that staff were appropriately supervised, to enable them to deliver care and treatment to people safely and to an appropriate standard.

The above issue is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records showed that people had access to healthcare professionals such as GPs, dieticians, and speech and language therapists. Staff told us it was easy to acquire GP support when people developed specific health needs. Handover process gave staff information on each person's current health needs and how to provide support, for example, extra pillows to assist with breathing difficulties. Arrangements were also made for obtaining health professional advice where judged as needed, and to support people to attend community healthcare appointments. This helped assure us that people received ongoing healthcare support at the service.

Good

Is the service caring?

Our findings

Most people told us they were happy with how staff interacted with them. Comments included, “They’re very helpful”, “Staff are very good on the whole, they do their best”, “Staff are easy to talk to,”, and “They put their whole heart into the job; they make me feel very important.” Visiting relatives were similarly complimentary about the care provided, for example, “The staff are very good, you can’t fault them.” People told us that they could have visitors anytime, and we saw this to be the case.

We saw that people were well-dressed, and had had their nails and hair attended to, meaning that where needed, staff provided this support. We also saw that the service had a visiting hairdresser and a private area on site for this purpose.

We saw staff interacting with people in a patient and sensitive manner, for example, when they provided support with taking medicines, and when working with people whose behaviour was challenging the service. Staff listened to people when offering care and support, and our discussions with staff showed that this was a key value of the service. Staff spoke with care about the people they were supporting. A newer staff member could tell us about people’s individual needs, which helped assure us that they had been supported to develop positive relationships that respected people’s individual needs and preferences.

We heard staff interacting in a kind and friendly manner when providing support to people in their rooms. We saw that doors were closed when providing personal care. Staff knocked on doors and waited for permission to enter, which helped respect people’s privacy. When staff engaged with people, they gave polite and personalised attention.

The service specialised in the care of Jewish people. People told us that their culture was respected by the service, such as through festivals taking place and through a local Rabbi visiting weekly. “They understand Jewishness,” one person told us. The management team told us staff received training on Jewish values so as to help uphold people’s cultural identity. They told us of plans to improve the standard of cultural services, principally through working towards a culturally-recognised accreditation.

Requires Improvement

Is the service responsive?

Our findings

We checked four people's care plans. They were based on pre-admission assessments of people's needs. They included details of the person's individual needs and how staff should provide support. For example, plans considered people's personal care, health, and activity needs and preferences. They had been recently updated. However, we found that two of the four care plans did not reflect their current needs, which may not have protected them against the risk of inappropriate or unsafe care.

One person had an updated risk assessment on pressure care which recorded them as at high risk of developing pressure ulcers without intervention from the service. They had no care plan relating to the management of pressure care. We additionally noted that the person's care plan had not been updated following a recent period in hospital, despite hospital discharge documents showing evidence of increased care needs.

Another person was assessed as being at risk of pressure sores. Records in their room stated that the person could not turn independently in bed, and so staff were to support them with two-hourly turns at night. However, there was no care plan to address this, and only one record in the four previous days of turns taking place. Turning charts, to help accurately document the support provided, had not been set up, although blank charts were available for this person in the office. We spoke with a member of the management team who confirmed that the person needed turning at night. We were not assured that the person had been supported to turn at night as per their identified needs.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with a member of the management team about how staff were made aware of people's updated support needs. Along with the expected update of care plans, they told us that there was no written record of handover and so new information about changed needs was passed on verbally. We found, however, instances where people's specific needs had not been communicated effectively to ensure staff provided the necessary support. For example, one person was not being supported to turn at night, to address identified pressure management risks. Another person was not having their fluid intake effectively monitored despite recent health professional advice of increased risks of dehydration. This did not assure us of effective communication amongst the staff team in support of ensuring that people were well cared for.

The provider's complaints policy gave details on expectations around complaint handling and resolution, however, it did not include information on how the procedure was brought to people's attention. We asked the management team where there was information on display about making complaints, but they were unable to demonstrate this. We also noted that the provider's website did not make reference to a complaints process. We were not assured that the complaints system was being brought to people's attention in an effective manner.

The complaints policy did not have information on how people could be supported to make a complaint where assistance was needed. We spoke with one person who told us of having to rely on a relative to be responded to, as their direct feedback to staff in the service did not result in action that they felt resolved the matter. This did not assure us that people were effectively supported to use the complaints system where support was needed.

We asked the management team to send us a summary of complaints and responses across the last six months. We received a statement "13 have been recorded. Mainly to do with food provision" along with two sentences of actions being taken about food. When we asked for specific details of each of the 13 complaints, we received no reply. This was despite the complaints policy stipulating that a complaint log was to be kept at each of the provider's service along with specific records of each complaint. We were not therefore able to check how effectively the 13 complaints had been responded to, but the lack of detailed reply raised concerns about the service's ability to identify complaints and to keep the complaint log identified in their policy up-to-date.

There were other means by which people could inform the provider of their views about the service. We saw minutes of the last two meetings for people who use the service, and of separate meetings for family and friends, to discuss the services provided. These took place on a quarterly basis with members of the service's management team. They captured attendees' views of what the service was and was not doing well at. However, they did not clearly record the specific actions that would be taken to address any concerns, nor review matters arising from the previous

Requires Improvement

Is the service responsive?

meeting. The April meeting for people using the service stated that a further meeting would occur in May, to report of progress, however, according to the records given to us on request, it did not occur.

The last of these two meetings, both held in August, raised concerns about people having to wait too long for staff support, including through delays in responding to call-bells. However, we saw that the monthly provider visit report for September recorded 'no current complaints open' as the only entry under the section titled complaints, and made no specific mention of people having to wait for staff to respond. At our inspection, we heard from people that they continued to have to wait for staff support, and we saw evidence of this occurring. This did not assure us of the service having an effective system in place to identify and respond to concerns and complaints.

The above issues are a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said there were enough activities provided in the service. One person showed us a weekly activity program organised by a designated staff member. During our visit, we saw that many people enjoyed taking part in a reminiscence session that covered topics such as films, music and socialising. After lunch, a visiting entertainer played piano and conducted a sing-along amongst the many attendees.

People using the service and staff told us that the service had recently acquired a new minibus, which enabled more outings to be organised and enjoyed by people. A trip to a large shopping centre was planned for the next day, and was much anticipated amongst some of the people we spoke with. People's comments also included, "There's entertainments, discussions, and talks." and "I go to day centres for a change of scenery; variety, and the people you meet there." We also noted positive feedback about activity provision through the recent service-delivery meetings for people using the service and their representatives. We were assured that the service enabled people to take part in activities of their choosing within the service, and where possible, within the community.

Requires Improvement

Is the service well-led?

Our findings

The manager in post at the last inspection of May 2014 left the role towards the end of August. We were informed of this through involved health and social care professionals in early September. With prompting, we received an email in early October from a representative of the provider informing us of the manager's resignation on an unspecified date, and the arrangements for management of the service. This delay in keeping us informed did not assure us that when there were significant changes to the service, the quality and safety of the service would be maintained.

This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

The provider had arranged for a senior manager to be based at the service shortly after the manager's resignation, to help the incoming manager who began working at the service at the start of October 2014, and to address the concerns arising from a detailed whole-service audit undertaken by the provider's quality team during August 2014. An action plan to address that audit was set up, and we saw that some concerns had been addressed, most notably for care planning and documentation.

Some people we spoke with expressed views about the turnover of managers and inconsistency of approach. We received a few comments about the new manager being "off sick a lot", however, this was balanced with consistency being provided by the remaining management team based at the service, who demonstrated good knowledge of the needs of individuals using the service during our visit.

Staff told us that they worked well together but that there used to be more staff working in support of meeting the needs and preferences of people using the service, and that they were challenged by staff turnover. However, they felt that support had improved since the temporary positioning of the senior manager in the service.

We were shown the results of a recent consultation put to people about the importance of certain aspects of the service, for example, the environment, activities and food. The management team told us of actions being taken as a result of the overall feedback, which aimed to improve on services to people in these specific areas.

At our last inspection in May 2014, we were told that surveys had been sent out to people using the service and their representatives, to ask for their views of the overall service. At this inspection, the management team were not able to say how that process had been used to assess the quality of the service and make improvements where appropriate. They could only find a small number of returned surveys, and were not aware of actions taken in response.

We were given a copy of the provider's quality assurance policy that was dated as due for review in December 2013. It clarified different ways in which quality standards within the provider's services were measured so that improvements could be made where needed. It included information on how the management team within the service self-audited quality, such as for monthly accident analysis which we saw had taken place in support of identifying and taking action on trends. The policy also stipulated how the provider's quality audit team conducted full audits at least annually, and that a senior manager on behalf of the provider would record monthly visits to overview standards.

We looked at the last monthly visit, for September 2014. It recorded a brief overview of three visits by the regional manager during September. Whilst it showed evidence of discussions with people using the service and their representatives, it did not record any such discussions with staff or identify that staff supervisions had not taken place since May for most staff, despite that being an identified area to record about on the form used. It included no dates of the last fire or health and safety audits despite specific prompts for that information. It recorded that there were no open complaints, despite clear expressions of concerns and complaints from the August Friends and Family meeting. It included a single statement of 'No reportable incidents at the time of visit' under 'Record of Events' that included notifications to us. The report also stipulated for safeguarding events to be documented, for which there were none. This was in contrast with the two notifications the service sent us about accidents that occurred to people during September, before the final date of visit recorded on the provider report. One of the falls was considered under the local authority's safeguarding procedures. The lack of information contained in September's monthly report did not assure us of effective monitoring of quality and risk at the service.

Requires Improvement

Is the service well-led?

We noted that the provider's complaints policy included for quarterly review of all complaints, to establish trends and lessons learnt. The quality assurance policy included that complaint investigations were to be monitored and reported monthly. However, we were not sent detailed information on request about complaints across the last six months, and when we then asked for evidence of complaints monitoring and auditing across the last six months, we received no reply. Additionally, we found that people using the service were not sometimes responded to in a timely manner, which had been raised by people using the service and their representatives in formal meetings three months previously. We were not assured that the provider's quality monitoring system was effective at having regard to people's complaints and comments.

When we checked that people's call-bells worked, we found one that did not and another was not accessible. We found a record identifying the broken call-bell from six weeks earlier. This did not assure us that the provider had an effective system for identifying, assessing and managing risk in relation to call-bells so as to protect people using the service against the risks of inappropriate or unsafe care and treatment.

The ineffectiveness of the provider's system of quality and risk auditing was also demonstrated through the breaches of regulations we found during this inspection that had not been managed by the provider before our visit. For example, although there had been some specific medicines auditing as a result of the provider's whole-service audit, we identified instances where people did not receive their medicines as prescribed, which may have had an impact on their health and welfare.

The above issues are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person failed to protect service users against the risks of inappropriate or unsafe care, by means of the effective operation of systems designed to assess and monitor service quality, and identify, assess and manage risks. Regulation 10(1)(a)(b)(2)(b)(i)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person failed to have suitable arrangements in place, in relation to the care provided for service users in accordance with the Mental Capacity Act 2005, for obtaining, and acting in accordance with, the consent of service users or others lawfully able to consent on their behalf, or where applicable, establishing, and acting in accordance with, the best interests of the service user. Regulation 18(1)(a)(b)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person failed to have an effective system in place for identifying , receiving, handling and responding appropriately to complaints and comments made by service users and persons acting on their behalf. Regulation 19(1)(2)(a)(b)(3)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person failed to have suitable arrangements in place to ensure that staff were appropriately supervised to deliver care to service users safely and to an appropriate standard. Regulation 23(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes The registered person failed to give notice in writing to the Commission, as soon as reasonably practicable to do so, when a person other than the registered person managed the regulated activity. Regulation 15(1)(a)

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person failed to take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure their welfare and safety. Regulation 9(1)(b)(i)(ii)

The enforcement action we took:
We served a Warning Notice on the Registered Provider on 05 December 2014, to become compliant with the regulation by 30 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person failed to protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, using, and safe administration of medicines used for the purposes of the regulated activity. Regulation 13

The enforcement action we took:
We served a Warning Notice on the Registered Provider on 01 December 2014, to become compliant with the regulation by 30 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person failed to protect service users from the risks of inadequate nutrition and dehydration, by means of:

This section is primarily information for the provider

Enforcement actions

• the provision of choice of suitable and nutritious food and hydration, in sufficient quantities to meet their needs, and

• support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.

Regulation 14(1)(a)(c)(2)

The enforcement action we took:
We served a Warning Notice on the Registered Provider on 01 December 2014, to become compliant with the regulation by 30 December 2014.