Four Seasons Homes No 4 Limited

Park Farm Lodge

Inspection report

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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?	**Inadequate**

Overall summary

This unannounced inspection took place on 7, 8 and 13 January 2015. Park Farm Lodge Nursing Home provides accommodation and care for up to 80 people who have nursing needs or are living with dementia. At the time of the inspection 56 people were accommodated at the home.

There was no registered manager at the service. The previous registered manager left in April 2014. 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.

A new manager was recruited recently however the provider has told us that this manager will not remain at the home. A new manager from one of the provider's other care homes has moved to Park Farm Lodge as the new manager.

After inspections in January, June and September 2014 we asked the provider to take action to make improvements to the way people were cared for, how

Summary of findings

records were kept and to make sure there were sufficient suitable staff to provide people's care. Following those inspections the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if the improvements needed had been made.

The home was not well led. There was no registered manager in post. There has been a lack of management continuity. Some areas for improvement previously identified by the provider had not been effectively addressed. The issues around the staffing arrangements had not been effectively acted upon. This meant that there were times when care was delayed or not provided in a personalised way.

People's medicines were not being managed safely. The current arrangements did not make sure people always had their medicines as they had been prescribed.

People's nutritional needs were assessed and plans were in place to support people to have sufficient to eat and drink. Some people told us they enjoyed the meals and choice was provided. Some people did not have a choice of meals and sometimes people had to wait to have their meals. The times between meals could be too long or too short.

Improvements had been made in providing things for people to do but activities were not fully based around people's interests and hobbies. People living with dementia needed more support to have their social and emotional needs met. The provider's dementia care programme had not yet been implemented.

People told us that staff were caring and treated them nicely. We observed people being supported in a caring and compassionate way. We saw some occasions when people's dignity was not promoted.

The provider had taken action in response to any reported safeguarding incidents. Some incidents were still being investigated. Care staff were aware of signs of abuse and how to act upon concerns.

Risks to people were identified and plans were in place to keep people safe. Care for people to prevent and manage pressure ulcers had overall improved. Records were being better kept and more regularly checked to make sure people received safe care.

People were supported to receive appropriate health care support. This included seeing the GP, optician and health care therapists.

Staff had been trained and understood the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA set sets out the actions that need to be taken to make sure when people cannot make their own decisions this is done in their best interest.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires Improvement

The service was not consistently safe.

Medicines were not managed safely. Some people did not get their medicines as prescribed.

Staffing arrangements needed to be improved to make sure that care was personalised and provided in timely manner.

Risks to people were assessed and plans were in place to provide safe care. Care staff knew about signs of abuse and how to respond. Incidents of abuse had declined although some concerns were still being investigated.

Is the service effective?

Requires Improvement

Care was not consistently effective.

People were supported to eat and drink but the mealtime experience for some people could be improved. Some people did not have a choice of meal and sometimes had to wait for their meals.

People had access to healthcare support that met their needs. They received support from their GP, the optician and a range of health care therapists.

People's rights were protected because the Mental Capacity Act 2005 Code of practice and the Deprivation of Liberty Safeguards were followed when decisions were made on their behalf.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were supported by staff that were caring and who spoke with them respectfully. There were times when people's dignity was not promoted.

Relatives were welcome to visit at any time and were involved in discussions about their relative's care.

Is the service responsive?

Requires Improvement

The care was not consistently responsive.

People's needs were assessed and plans of care were in place. People's preferences were not always fully recorded although staff knew about people's likes and dislikes. Care was not always provided in a way that met people's individual needs.

The overall provision of things for people to do had improved. However improvements were needed to make sure that the emotional and social care needs of people living with dementia were fully met.

Summary of findings

People were aware of how to raise concerns and told us their concerns were listened to.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post and the management arrangements had been unstable for some time. Care staff and relatives had concerns over the way the home was led and managed.

Some improvements to people's care had been made. However shortfalls that the provider has been aware of for some time had not been effectively acted upon.

Arrangements were in place to gain the views of people living at the home and their relatives. Relatives did not always feel their views were acted upon.

Park Farm 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.

The inspection took place on 7, 8 and 13 January 2014.The first day of the inspection was unannounced.

The inspection team was made up of three inspectors, a pharmacy inspector, two specialist professional advisers; one a tissue viability specialist and one a specialist in infection control, 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. The expert had knowledge of older people.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included incident notifications they had sent us. We spoke with two health care professionals to gain their views of the care people received.

Before the inspection we also considered information about the quality of care received by the people who used the service. These concerns included safeguarding referrals. As a result of the number of concerns raised, the Local Authority (Safeguarding Team) had commenced a Large Scale Investigation (LSI) of the service. An LSI is organised by a Local Authority when a significant number of safeguarding concerns has been raised about a provider and there are significant concerns about the safety and welfare of people who used the service. We had attended LSI meetings where information relating to the home was shared and discussed with relevant professionals. Due to this process the provider was not admitting new people to the home.

We undertook several periods of observation including in dining rooms and in lounges. We spoke with 10 people who used the service, ten relatives and five social and health care professionals. We spoke with the regional manager, two deputy managers, three nursing staff, six care staff, the activity co-ordinator and members of the catering staff and housekeeping staff. We looked at 19 medicine records and eight care records and some documents relating to the management of the service. These included three staff recruitment files, quality audits and minutes of meetings.

We also considered a draft report of a visit by Staffordshire Healthwatch. Healthwatch are an independent consumer champion for health and social care. We also looked at a recent local quality monitoring report completed by the local authority that commissions services at the home.

Requires Improvement

Is the service safe?

Our findings

At our inspections in March and June 2014 we found the provider needed to make improvements to the staffing arrangements. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. They provided us with information following those inspections to tell us how they would make improvements.

A number of relatives told us they felt there were not enough staff on duty. One relative told us; "We (relatives) are all concerned about staffing levels but I feel my relative is safe here". Another relative said; "I have visited and found people have not had their drinks and at Christmas staff were apologising because they were not able to provide the support my relative needed." This relative said they assisted the staff by helping to give gave people drinks. Some relatives were concerned about the number of agency staff used to provide care to people. They also raised with us that call bells were not answered quickly enough. We considered this during the time we were at the home and did not identify any incidents when there was an excessive delay in responding to call bells.

Care staff said they felt very rushed and had little time to speak with people. They said that some people's care was delayed. More than one staff member told us they felt there were not enough staff. One said ; "We need more staff, people's dependency is high, we're short of staff".

We observed that care on the unit for people living with dementia was provided in a task focussed way and was not provided in timely manner. Care staff went from room to room providing personal care and support rather than responding to each person's individual needs. We observed that meals were delayed and some people were still in bed until lunchtime and the senior staff could give us no reason for this.

The provider told us that the current staffing levels were sufficient to meet people's nursing and personal care needs although they acknowledged that over the Christmas period staffing had been below the required level. A staffing tool was in place that took into account the needs of each person when assessing the level of staffing required. Checks on rosters showed that overall the staffing levels routinely exceeded the identified levels. Where there were gaps in the roster agency staff were used. The provider told us that they believed the issues identified were due to a lack of effective staff management and organisation. This is what we were told when we had previously looked at the staffing arrangements and any changes made by the provider had not resolved the issues.

At our inspection in September 2014 the provider needed to make improvements to the care and welfare of people particularly in relation to preventing and managing pressure ulcers. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. They provided us with information to tell us how they would make improvements.

Some people needed support to maintain a healthy skin. People's skin was regularly assessed and plans were in place. These included the type of equipment people needed and the support to minimise the risk of pressure ulcer occurring. We saw that the provider had put in systems to check and monitor care provided to people with a pressure ulcer. Many people needed to have their position changed regularly to relieve pressure on areas of their body where ulcers can develop. Checks on records and discussions with staff showed that people had their position changed although the records indicated that on a few occasions people were left longer than the recommended time. We saw that the provider had introduced a checking system to monitor that position changes were taking place. We saw that people were using the necessary pressure relieving equipment to promote a healthy skin.

Information from a health care professional confirmed that overall this type of care had improved although there had been one instance when a person's condition had deteriorated because medical advice had not been followed. We are aware that this is currently being investigated as a potential safeguarding incident.

At this inspection we looked at the management of medicine. Although three people we spoke with told us they had their medicines regularly we found that people's medicines were not being managed or handled safely.

We could not always be assured that people were being given their prescribed medicines as intended to treat their diagnosed healthcare conditions. We found that the recorded amount of some people's medicines was not accurate. It is important to ensure that it is possible to check that people have been given their medicines. In

Requires Improvement

Is the service safe?

particular we looked at one person prescribed a medicine that needed careful monitoring to ensure a safe dose was given to the person. We were not able to check that they had received their medicine had been given as prescribed because the total amount of medicine available did not match the records of receipt or administration. Our checks also showed that three people had run out of their prescribed medicines and one person had not been given their medicine for four days despite the medicine records documenting that the medicine was available. The failure to give these medicines could lead to deterioration in their health.

Medicine records did not always accurately document that people had been given their prescribed medicines. We found that sometimes there was no staff signature to record the administration of a medicine or a reason documented to explain why the medicine had not been given. We also found that a medicine for one person was still available in their medicine pack for one day; however their MAR chart had been signed for administration for that date. This meant that this person had not had their medicines.

Nursing staff did not always identify when people should be referred for a medicine review with the doctor. We identified that two people were not being given their prescribed medicine because they were asleep at the administration time. We raised this issue with the nursing staff who agreed they would discuss changing the times of administration with the doctor.

Supporting information for staff to safely administer medicines was not always available. We looked at three people who were prescribed a medicine to be given 'when necessary' or 'as required' for agitation. Although nursing staff we spoke with were able to explain when they would give the medicine there was no supporting information available. This would help to enable staff to make a decision as to when to give the medicine. We further noted that when people were given a medicine prescribed for agitation there was not always a record to explain why the medicine had been given.

Care staff we spoke with told us they applied prescribed creams to people when they supported them with their personal care but this was not always recorded.

This meant that the registered person had not protected people against the risk from unsafe medication administration. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that systems were in place to manage risks to people. These were regularly reviewed and updated. Some people needed support to move safely and we observed several people being moved with the use of a hoist. We saw this was done safely. Care staff confirmed they recently had their manual handling training updated following a serious incident that had occurred. One of the people we checked was at risk of falls. We saw that action had been taken to ensure they had a low bed and crash mats. Hourly checks were completed to ensure they were kept safe.

People told us that they felt safe at the home and did not have any concerns about bullying from staff. One person told us; "I feel able to speak with the staff about any concerns I have, they will help you if they can". Another person said; "I feel very safe here. The staff are marvellous". Relatives we spoke with also spoke highly of the permanent care staff. One of the relatives we spoke with said; "I feel my [relative] is safe here".

Staff told us, and records confirmed they received training in safeguarding vulnerable adults. We spoke with three members of staff who were able to tell us how they would respond to allegations or incidents of abuse. They all told us they would have no hesitation in reporting any incidence of poor practice. We are aware that staff members have brought allegations of abuse to the attention of managers by staff members. The provider has appropriately referred allegations of abuse to the local authority for investigation.

There have been a high number of potential incidents of abuse reported. A number are still being investigated. We have seen that the provider took action to address incidents of abuse and an action plan is in place to further act upon concerns. There has recently been a reduction in the number of reported incidents.

The provider had a recruitment process in place. Care staff told us that they had a number of checks before they started work. All except one record we checked confirmed that the necessary checks were completed to make people

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Is the service safe?

were suitable to provide people's care. We brought this to the attention of the regional manager who took action to address this omission. This person had not been working so did not pose a risk to people.

We looked at the way the staff managed hygiene and infection control as we had been made aware of concerns. One person told us; "The home is very clean and tidy, the staff do work hard to keep it nice for us". A relative told us that the home was bright and tidy, although felt the décor of some areas could be upgraded.

The provider managed the control and prevention of infection well. Concerns raised following a recent audit of equipment had been promptly addressed. The housekeeping manager had a very good knowledge of infection prevention and control and was able to explain and describe what detergents and cleaning fluids were used throughout the home. We observed that appropriate protective equipment was used to prevent the spread of infections. Care staff we spoke with were clear about their role in the prevention and control of inspection. They were able to describe when they would wear personal protective equipment and also outline the procedures they would carry out when undertaking cleaning duties. All staff had received infection prevention and control training.

The home did not have a designated a single person to take the lead on infection prevention and control but had link nurses responsible for infection prevention control on both the floors.

Requires Improvement

Is the service effective?

Our findings

We received mixed views about people's mealtime experience. Two people told us that they felt there was always sufficient food and that an alternative meal was available if people did not like the choices. However when we spent time in dining rooms a choice of food was not evident. Within the dining rooms for people living with dementia a choice of food was not evident on the menus boards. One board was not completed and when we asked care staff about the lunchtime menu they were unsure what choices were available. The deputy manager told us there were pictures of food to support people to make decisions but these were not being routinely used. Some people needed a soft or pureed diet due to swallowing difficulties. We were told there was no choice for people who needed this type of food. A relative told us there was little choice at tea time. The menu we saw indicated that soup and sandwiches was the meal on offer every day. We raised this with care staff and they told us there was a large variety of choices but these were not on the menu board. It was not clear how people were made aware of these other choices.

One relative said that they did not think the food was well presented and brought food in that the staff cooked. Another relative told us; "The food is not bad and is always hot".

We spent time observing in two of the dining rooms. We saw that people in the ground floor dining room were well supported although they were seated for 30 minutes before the meal arrived from the kitchen. The meal was nicely presented and was warm. Adapted cutlery and crockery was provided to support them to eat independently. We saw that when one person did not like the meal they were offered an alternative. We observed care staff were attentive and demonstrated a good knowledge of people's likes and dislikes.

In one of the other dining rooms we saw eight people needed support to eat their meals. There were two care staff available. This meant some people had to wait for their meal. A significant number of people took their meals in their bedroom and needed individual support to eat and drink. We observed that on one day breakfast was not finished until 11.30am. Staff told us that this was due to the high number of people who needed support. Lunch started to be served around 13.00pm. We asked staff if a record was kept of the people who had a late breakfast to make sure their meals were not too close together. We were told there was no formal record but staff tried to remember when people had their meals. This meant that the gaps between meals may be too short.

Some people were at risk of not eating and drinking enough and plans were in place to support them to have adequate nutrition. People were regularly weighed and we saw evidence that people were referred for specialist support when there were concerns. This was confirmed by two health care professionals we spoke with. We saw evidence that people's food was monitored although it was not always clearly recorded whether people had snacks during the day or had eaten supper. We raised this with care staff and the cook who confirmed that this food was provided. We saw records were kept of the amount people drank including fortified drinks. In a small minority of these there were gaps. We raised this with one of the nurses and they showed us they had implemented a system to regularly check these records and confirmed that action was taken when records were not fully completed.

We saw evidence that the manager had identified improvements that would improve people's mealtime experience. This included providing more support for people to eat their meals. These changes still needed to be put in place.

People were complimentary about the permanent care staff. One person said; "The staff seem to have the correct training". Another said; "They [staff] seem to have the correct skills to care for us". A relative said; "In general the quality of staff has improved over the past year".

Staff told us they were trained to undertake their role. This was confirmed by the records we saw. Where staff needed to update their knowledge the provider had systems in place to follow this up. We observed a number of care staff supporting people and we saw this was done in a confident and caring way. Care staff undertook a period of induction training when they started work at the home. This was confirmed by a care staff member who was on their first day at the home. They told us they were an extra care staff member and were not on the roster. The provider used a significant number of agency staff. An agency staff member we spoke with confirmed they were experienced and trained to provide people's care. They told us they undertook a short induction training when they first visited the home.

Requires Improvement

Is the service effective?

People had access to healthcare professionals including doctors, an optician, a chiropodist and health care therapists. One person told us; “You only have to tell the staff you want to see the doctor and he comes to see you.” Staff told us that a GP visited the home several times a week and therefore any health care issues could be quickly addressed. One person told us that an issue previously raised had not been acted upon. We were satisfied when this was raised with the nurse on duty action was immediately taken. We spoke with a GP and they told us there was a good working relationship between the care and nursing staff and the GP practice. They told us that the nursing staff identified changes in people’s condition and referred for medical support correctly. . They confirmed that when medical advice was given the staff acted upon it.

Staff we spoke with told us they had been trained in the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA sets out the actions that should be taken in people’s best interest when they are unable to make their own decisions. We saw examples of assessments to check people’s capacity to make decisions and of when decisions had been made in their best interest. Staff were able to give us examples of when they had sought people’s consent to support them with personal care tasks. The DoLS protects people who need to have restrictions placed upon them for their safety. We saw that some people needed restrictions and that the required DoLS applications had been made.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were positive about the qualities of the care staff. One person said; “We get a lot of care and attention”. Another person said; “I feel the staff genuinely care for me”. We spoke with a number of relatives who regularly visited the care home. They told us that although they did not feel there was sufficient staff they said the care staff worked hard and were caring. One said; “I want to praise the staff, they all show love to my relative”. Another person said; “The quality of the staff has improved and they are caring and listen to the relatives”.

We observed that care staff completed their duties in a caring manner. We observed two nurses giving people their medicines. Both nurses were kind and patient allowing people time to take their medicines. We also observed one person being moved with a hoist. The staff were kind and considerate and provided the person with reassurance. At lunchtime we observed people being supported to eat in an attentive, caring and compassionate manner.

We saw examples where care staff spoke with people in a respectful manner and used their preferred name. Care staff did not enter people’s bedrooms without knocking and seeking permission. A healthcare professional told us they felt staff were caring and had good relationships with people that lived at the home. They told us they had seen staff and people that lived at the home having a laugh and a joke together. We also saw times when people’s privacy and dignity was not promoted. We observed people sitting in the lounges unsupervised and on one of these occasions we saw one person was unsettled and was pulling their continence pad off. In another instance one person’s clothing had ridden up exposing their leg. We observed in one of the dining rooms a person’s nose was running. We saw in this person’s record that their appearance was very important to them. We needed to alert staff to these incidents.

Families we spoke with told us that they were able to visit their relatives whenever they wanted. They said that there were no restrictions on the times they could visit the home.

People and relatives told us that they were involved in decisions about their care. One relative said; “We recently had a review of the care.” Records we checked showed contact with relatives to ensure they were kept informed and to gain their views. We saw care staff seeking the views of people living with dementia but did not see any additional support such as pictures and objects available to support people to understand information and make decisions.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection the provider needed to make improvements in the way records were kept. This was a breach of Regulation **20** of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had sent us a plan showing us how they would improve.

Care records were in place that included information about people's health and personal care needs. Most of the records we looked at were up to date and had been reviewed every month. This meant that information about these needs was up to date. Records contained limited information about people's individual preferences and their previous interests and hobbies. A file in each person's bedroom included a form where this information should be recorded. In the majority of records this form was not completed and there was limited information to tell care staff about things that were important to people. We did see that in some instances information about people's previous lifestyle was in a box outside their bedroom.

We saw that records relating to people's individual care were improved. Our checks on records such as food and fluid and position changes had improved although we saw a few gaps. We saw that the provider had put in place a system of checks to look at records on a regular basis. This would enable any gaps to be quickly picked up and acted upon. Information from the latest local authority quality and monitoring visit confirmed that record keeping had improved.

The provider told us that the organisation was in the process of introducing new plans of care and recording documents. They felt this would lead to further improvement in the quality of the records.

We received mixed views from people and relatives about whether care was responsive to their individual needs. One person told us; "They look after us alright here". One relative who visited every day said; "My [relative's name] is safe. The staff know what [relative's name] likes". Another relative said; "This is a good place. They look after [relative's name] well". Whilst another relative said; "Whilst in general the quality of staff has improved it's the little things they fail to do". We saw some positive examples of personalised care being provided including at mealtimes and when people were provided with support in communal rooms. The provider had recently introduced a 'resident of the day' system. This meant that one day a month particular checks were made on the person's care and discussions took place with the person and their relatives to check care met their needs.

Care staff we spoke with knew about people's preferences and background. They described how one person particularly liked music and if they became anxious they would put music on to try and help them to settle. They told us about another person's previous lifestyle that meant they often did not want to get up until lunchtime.

We observed that on the unit for people living with dementia care was provided in a task focussed manner. We saw care staff moving from room to room providing personal care and support rather than responding to each person's individual needs. Care staff told us they had to work this way to try and ensure everyone had their nutritional and personal care needs met. We observed in the lounges that interaction with people was based around the tasks being undertaken. One care staff member told us; "It's all very upsetting when all someone wants is five minutes of your time and you just can't spare it".

People and relatives told us that care was not always provided in a timely way. One relative we spoke with told us that their relative was not washed until approximately 12pm and said that on the day before had not been shaved by lunchtime. This supported what we saw. On one day we observed people were still having breakfast at 11.30am and at 12.15pm fifteen people were still in bed. When we asked senior staff the reason for this they were unable to explain why this was the case and told us they would institute an immediate investigation. On a previous day people who needed to be moved with a hoist could not get up until lunchtime. We were told this was because the hoist slings were being checked. The provider could not tell us why following a sling being checked they were not brought back into operation. This would have enabled people to be moved safely and to receive the care they needed.

One person told us there had been lots to do before Christmas; making cards and taking part in a range of entertainment. We saw a staff member supporting some people to take part in group and individual activities including bingo, flower arranging and a musical session. We saw these were enjoyed by most people who attended. One person told us they went to a religious service

Requires Improvement

Is the service responsive?

conducted by a local minister and this took place every month. However there was no information to show that people's individual interests had been taken into account when planning and implementing these activities.

We saw there were times when people living with dementia were sitting in the lounges and had nothing to engage or interest them. The home had a bar room and a café but we did not see these facilities being used. We saw there were few sensory items for people to hold and engage with. This is an area that the provider had previously told us they knew needed to be improved and is on their action plan. The regional manager told us due to the high number of people with physical nursing care needs currently on the unit for people living with dementia care; staff were finding it hard to fully respond to the social and emotional needs of people whose primary need was for dementia care. The provider told us they had started to address this. We are aware that some changes had been made and some staff training provided to support people living with dementia. We were told that the provider had recently approved an increase in staff hours to support activities. The provider has a specific dementia care programme but this has not been implemented at the home.

The provider had a complaints procedure. This was displayed in the entrance hall. One person living at the home told us; "If I have any complaints the staff always look at them straight away and sort them". We spoke with a number of relatives and they told us they knew how to make a complaint. People who had made a complaint told us they had been listened to and their concerns had been taken seriously. We saw that complaints were logged and responded to.

Inadequate

Is the service well-led?

Our findings

The provider has systems in place to review and monitor the service. An action plan was in place in response to the shortfalls that were identified following previous inspections, local authority quality and monitoring visits and from the outcome from safeguarding incidents. The provider has been aware of the areas that needed to be addressed for some time and we saw some areas where care for people had improved. We also saw that actions taken had not been effective in making the changes needed to improve people's care. The provider had identified before our inspection in June 2014 that the management and organisation of staff needed to be addressed. Actions taken by the provider had not been effective and on this inspection they again told us that staff were not well managed and organised. During 2014 the provider told us that people did not have enough to do and this had still not yet been fully addressed. The provider organisation has its own dementia care programme and had told us this was to be introduced. This had not been done.

Audits had been completed including the way people's medicines were managed and about people's mealtime experience. Both had identified the shortfalls we had seen. Incidents and accidents were recorded and we saw that an analysis of these events had taken place for the month of October. This identified a number of actions that were aimed at reducing these incidents. Due to the absence of the manager these areas for improvement had not yet been acted upon.

This meant that the registered person had not protected people against the risk of harm because the systems for assessing and monitoring the service were ineffective. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a history of management instability. There has not been a registered manager working at the home since April 2014 and over the last 12 months there have been six different temporary managers. This lack of continuity has led to delays in implementing changes aimed at improving the service. The deputy director representing the provider told us they were committed to the home and in making the necessary improvements. We saw that the provider had altered the management arrangements by introducing two deputy managers with the responsibility for people's care in each unit.

Care staff gave us mixed views about the culture and management of the home. Some told us they were well supported and talked positively about the deputy managers/unit managers. They felt that the introduction of this management level had improved the organisation of the units. One care staff said; "We like [deputy's name] because they care about the residents". One person told us they had faith in the new manager to improve the care to people. Other care staff were concerned about the lack of stability both due to the changes in management and the high turnover of staff and use of agency staff. Some care staff told us that the morale was low and some felt their views were not always listened to. They said they were optimistic when a new manager was appointed and were positive about the plans they had to improve the service but felt demoralised when managers left. Care staff told us they wanted to have a permanent manager in post.

All care staff said they would have no hesitation in reporting incidents of poor practice and knew that any concerns would be promptly acted upon.

The provider sought the views of people who lived at the home and relatives. A recent survey had been completed but few people responded. Minutes of a 'residents' meeting' showed that people were consulted about activities, meals and changes to the environment. These issues are still in the process of being looked into. Meetings were held with relatives regularly. One relative said; "The meetings are worthwhile and productive". Others were less happy. They felt that their views were listened to but did not feel that their concerns were fully appreciated or addressed. This was particularly in relation to the staffing levels which they felt was inadequate. Shortly following the inspection the regional manager told us that in response to relatives' continued concerns about staffing levels they were to look at the roles of the nursing and senior care staff.

Most relatives we spoke with were concerned about the number of management changes that had taken place. They said each manager had their own plans to improve the care but due to the changes improvements were not sustained.

Inadequate

Is the service well-led?

The provider had implemented some changes to improve the service in response to concerns raised. These have included the 'resident of the day'; an improved handover system and a 24 hour activity reporting form to improve the monitoring of the quality of care people received. A system had been implemented to provide all staff with an individual supervisor and the first appraisals had taken place. We also saw that the provider had taken immediate action following a serious incident to retrain the staff to try and ensure the incident did not reoccur.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were not protected against the risks associated with unsafe or unsuitable care and treatment by means of an effective system in place to regularly assess and monitor the quality of the service. Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe use and management of medicines. Regulation12