Care UK Community Partnerships Limited

# Ellesmere House

**Inspection report**

9 Nightingale Place
London
SW10 9NG
Tel: 020 7352 6173
Website: www.ellesmerehousechelsea.co.uk

Date of inspection visit: 5 and 6 March 2015
Date of publication: 03/07/2015

## Ratings

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

## Overall summary

This inspection took place on 5 and 6 March 2015 and was unannounced. At our last visit in August 2014 the service was not meeting the regulations inspected. We asked the provider to send us an action plan outlining how they intended to make improvements to the service in order to meet the required regulations.

During this visit we found the provider had made improvements in a number of areas. However, despite evidence of positive changes, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to safe care and treatment and good governance.

Ellesmere House provides accommodation for people requiring nursing and personal care. The service is able to accommodate up to 50 people. At the time of our inspection 39 people were using the service.

The home is currently divided into three units. Two 15 bed units located on upper floors provide accommodation for people with nursing needs. A 20 bed unit on the lower ground floor is allocated to people living with dementia. Plans to re-configure the existing

# Summary of findings

ground floor space have been finalised and building works are due to commence at the beginning of April 2015. The plans include a new 20 bed elderly care unit along with a cinema and coffee shop.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was responsible for the day to day management of the service and was supported in her role by an operations manager, a deputy manager and a clinical lead nurse.

People's needs were assessed and care plans were developed to identify what care and support people required. Staff carried out a range of risk assessments covering areas such as falls, pressure area care, weight, diet and nutrition. However, we noted that people's repositioning, fluid and nutrition charts were not always completed accurately, consistently or effectively meaning we could not be assured that people were being protected against the risks of receiving unsafe or inappropriate care.

The home was cleaned on a daily basis but the service was not always maintaining and following policies and procedures in line with current relevant national guidance relating to infection control. We found out of date advice on infections and illnesses posted around the home and bathrooms which provided shared towels and open storage for unpackaged incontinence pads and toiletries. At the time of our visit the home was also being treated by pest control for an infestation of mice.

People were supported to take their medicines by staff who were patient and kind. However, on one occasion we observed staff leaving medicines unattended and accessible on top of the medicines trolley whilst administrating people's medicines. People's allergies to certain medicines were not always accurately recorded in their care plans. This demonstrated that staff were not always following safe procedures.

There were suitable recruitment procedures in place. Staff were employed on a permanent basis. Staffing levels were based on people's support needs and dependency levels. Some of the people living at the home, relatives and members of staff expressed concern that staffing levels were not always adequate to consistently meet people's needs.

Senior care staff had qualifications in health and social care and previous experience of working in care settings. Most of the staff caring for people living in the home had completed training in dementia awareness and were able to explain how they applied this learning in practice.

Staff supported people to make choices about the food they wanted. However, the lunch time meal we observed appeared chaotic. Food was delivered to people's rooms uncovered and therefore, hot deserts were likely to have been cold by the time people were ready to eat them. People's opinions as to the quantity, quality and choice of food on offer, was mostly positive although we heard from three people whose views about the food and the way in which it was cooked were negative.

Activities were scheduled to take place twice daily and the service had recently employed a full time activities co-ordinator to manage the activity programme. We saw people engaged in activities during our visit. One person living at the home told us they found the activities uninteresting and would like the opportunity to visit museums and parks and go to the theatre.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. Staff had received training in mental health legislation which had covered aspects of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Staff understood when a DoLS application should be made and how to submit one.

People we spoke with and their family members praised the staff highly and told us that they thought staff were kind, compassionate and hard working. All the staff we spoke with were courteous, welcoming and demonstrated a professional attitude as they carried out their duties.

# Summary of findings

We saw evidence that the home worked collaboratively with other health and social care professionals to ensure people received specialist care and treatment. Palliative care nurses and clinicians from therapy services visited people living in the home to assess their needs.

Staff demonstrated that they understood how to recognise the signs of abuse. Staff told us they would report any concerns to senior members of staff who would then assess the situation and report to local authority safeguarding teams, the Care Quality Commission (CQC) and to the police if and when appropriate.

# 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. Medicines were not always stored correctly and information about people's known allergies was not always recorded accurately.

The home was cleaned on a daily basis but the service was not always following policies and procedures in line with current relevant national guidance relating to the prevention and control of infections.

Staff completed a range of risk assessments covering areas such as falls, pressure area care, weight, diet and nutrition. We found that staff were not always following the recommendations and guidance set out in these assessments.

There were suitable recruitment procedures in place. Staff told us they attended interviews following the submission of successful job applications. We saw evidence that employment references had been sought and that criminal record checks had been undertaken prior to staff starting work.

**Is the service effective?**

Requires Improvement

Aspects of the service were not effective. People's care records included the contact details of people's family members, GPs and other healthcare professionals and/or relevant representatives. However, there was limited information about people's lives prior to moving into the home, for example; people's childhoods, working lives, significant places and people, interests and preferences.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received training in mental health legislation which had covered aspects of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

Opinions as to the quality and choice of food on offer were mostly positive though we did hear complaints from three people living in the home about the cooking methods used and the nutritional value of meals served.

**Is the service caring?**

Requires Improvement

Aspects of the service were not caring. We saw evidence that people were asked for their views about the care they received and how the service was run. However, we noted that minutes from a meeting held on 29 November 2014 contained no action points despite the many suggestions and requests that had been made by relatives.

People told us staff were kind and caring. All the staff we spoke with were welcoming and courteous and demonstrated a professional attitude.

# Summary of findings

Relatives and friends told us they were able to visit their family members whenever they wished. Visitors could see people in their rooms or in the lounge areas and outside in the garden.

**Is the service responsive?**

**Inadequate**

The service was not responsive. The home completed assessments for all people newly referred to the service. Not all sections of people's care plans had been fully completed and/or signed by the relevant parties.

We observed organised activities taking place during our visit which included cake baking and a famous faces guessing game. Some people using the service told us they had little opportunity to access the local community.

We saw that the provider had received and logged two written complaints since the last inspection in August 2014, relating to standards of care and the skills of nursing staff.

**Is the service well-led?**

**Requires Improvement**

Aspects of the service were not well-led. We saw that quality monitoring was undertaken to assess compliance with local and national standards. Whilst audits are identifying areas that require improvement, recommendations and action points are not always being followed through systematically.

The service had a registered manager who was responsible for the day to day management of the service and was supported in her role by an operations manager, a deputy manager and a clinical lead nurse.

There were processes in place for reporting accidents and incidents. We saw that the service used an incident tracker to record details of all accidents and incidents. This logging system also provided a brief analysis of what action followed and whether the police and/or local authority had been informed of events.

The service had a whistleblowing policy dated July 2014 which provided staff with guidance on how to voice their concerns.

# Ellesmere House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider had taken action to meet 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.

We carried out an unannounced inspection on 5 March 2015 and returned on 6 March 2015 to complete our visit. The inspection team included a single inspector and a specialist advisor with experience in nursing and the care of older people. We were also assisted by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses services, in this case services for older people and people with dementia.

Before our visit we reviewed information we held about the home including the last inspection report from August 2014 when we judged that the provider was not meeting the regulations we inspected. We reviewed the action plan the provider had sent to us in September 2014 to see if action had been taken to meet the regulations and what had been achieved as a result. We reviewed notifications we had received from the provider and other agencies since our last inspection. We also reviewed complaints and concerns reported to us by the relatives of people who use the service.

During our visit, we spent time talking with 12 people living at the home and five relatives. We spoke with the registered manager, the operations manager and the deputy manager. We also spoke with the clinical lead, two nurses, seven care staff members, an activities co-ordinator and the home's head chef.

We reviewed eight care records, six staff files and records relating to the management of the home.

We attended a 'residents and family meeting', observed a senior staff catch up meeting and briefly attended a dementia awareness in-house training session.

We looked at all the communal parts of the home and with people's agreement, looked at their rooms and bathrooms.

Following a serious safeguarding incident at the home prior to this inspection visit, we had been involved in a series of meetings and discussions with senior representatives from the home, local authority safeguarding officers, health and social care professionals and officers from various branches of the metropolitan police force.

After the inspection we contacted Healthwatch Central West London (an independent consumer champion for health and social care services) to discuss the findings of their visit to the service by its Dignity Champions in February 2014.

Inadequate

# Is the service safe?

## Our findings

Staff were not always completing people's repositioning, fluid and nutrition charts on a daily basis. Dietary and fluid charts did not always record sufficient information consistently or total the amounts of fluid people had taken. Repositioning charts were sometimes poorly completed with staff recording the length of time people had been seated in an armchair rather than confirming that people have been assisted to reposition themselves. Lack of effective monitoring and incomplete and inconsistent recording meant that we could not be assured that risks to people's health and safety were being assessed and monitored appropriately. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had given consent for the use of photographic identity records but not all medicine administration records (MAR) contained this type of information to protect them from the risk of medicine errors. Care plans were not always accurately recording people's know allergies. We saw that medicines were not always stored correctly. On one occasion during our visit we observed staff leaving blister packs of medicines on top of the drugs trolley unattended and accessible during a medicines administration round. We also observed one staff member administering eye ointment to a person sitting at the dinner table and noted they did not wash their hands either before or after completing this task. This meant that people were not always protected against the risks associated with the unsafe management and administration of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was cleaned on a daily basis but the service was not always maintaining and following policies and procedures in line with guidance relating to the prevention and control of infections. Signs posted throughout the home advising visitors about the spread of illnesses such as colds, influenza and norovirus were out of date. In communal toilet facilities we found a dirty hand towel available for shared use, loose toiletries being stored on open shelving and incontinence pads out of their packaging and placed on top of a waste bin. The home was being treated for mice by pest control at the time of our visit. This indicates that people living in the home, visiting and/or working in the home were not always being adequately protected against the risks of healthcare associated infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people using the service told us there were not enough staff on duty to meet their needs. One member of staff told us, "To fulfil the lives of these people we need more time and more staff." Relatives we spoke with expressed concerns about staffing levels particularly on the nursing units at night time. Following the inspection, one relative wrote to us and said "I'm concerned that there are now not enough staff to interact with my [family member] on a meaningful basis."

We discussed staffing levels with the registered manager who told us that normal staffing levels during the day were three care staff and one nurse for each of the 15 bed nursing units. A senior care worker and four care staff managed the 20 bed dementia unit. The deputy manager and clinical lead nurse provided further clinical support throughout the day from Monday to Friday. During the night, one nurse covered both nursing floors with the assistance of four care staff whilst the dementia unit was managed by a senior care worker and two care staff. During a relative's meeting, the operations manager informed family members that staffing numbers were based on people's dependency levels and were continuously reviewed to ensure numbers were adequate.

There were suitable recruitment procedures in place. Staff told us they attended interviews following the submission of successful job applications. We saw evidence that the required pre-employment checks had been completed to ensure that staff were suitable to work with people using the service. These checks included employment references and criminal record checks.

There were notices posted in staff areas to indicate the supervision responsibilities of senior staff members. Staff we spoke with told us they received regular supervision sessions and records we looked at confirmed this. The registered manager told us that all care staff had met their

Inadequate

# Is the service safe?

clinical and care delivery competencies. In literature produced by the provider, competency is defined as 'The ability to undertake and perform activities to a recognised standard on a regular basis'.

Staff completed a number of risk assessments covering areas such as falls, pressure area care, weight, diet and nutrition in order to identify any possible risks to people's health and safety. We saw that electronically recorded assessments were reviewed and updated in line with the provider's policies and procedures. We noted however, that updated copies of risk assessments were not always available in people's paper files.

The service had a safeguarding policy which had been updated in January 2015. Staff demonstrated that they understood how to recognise the signs of abuse and told us they would report any concerns they had to senior staff members. Senior staff explained that they would assess any potential safeguarding situation and report to the local authority's safeguarding team, the Care Quality Commission (CQC) and the police if indicated. CQC had been notified of a number of safeguarding incidents since the last inspection took place in August 2014. There was evidence to demonstrate that the provider worked closely and in collaboration with the local authority and the police to investigate and manage these matters.

Requires Improvement

# Is the service effective?

## Our findings

People's care records were divided between several different filing systems. Care records included the contact details of family members, GPs and other health care professionals and/or relevant representatives. There was limited information about people's lives prior to moving into the home, for example; people's childhoods, working lives, significant places and people, hobbies, likes, dislikes and preferences. One page profiles where this type of information could have been recorded were not always completed. We asked staff what they knew about the lives of people living in the home and noted that responses usually began with a breakdown of people's medical issues. One staff member told us, "I know everyone is different and the more we know about their previous life, the better we can care for them."

We saw that people were visited by a GP who came to the home on a weekly basis and more often if required. People told us they were able to get to appointments as needed although one relative told us that staff had not followed up an essential ophthalmology appointment for their family member.

We saw that assessments by various healthcare professionals such as tissue viability nurses, palliative care nurses and occupational therapists had been completed. We saw information posted around the home regarding the services of a visiting podiatrist and information available to people and their relatives about charities specialising in dementia.

There were daily menus on some, but not all of the dining tables. We observed staff supporting people to make their meal choices and were told the kitchen was able to provide alternative options if people did not like what was on the menu. We observed the lunch time meal being served on three floors and noted that on two of the floors, proceedings were chaotic and poorly organised. We saw food being delivered to people's rooms without covers which meant that hot deserts were likely to have been cold by the time they were ready to be eaten. Some people who required prompting and/or support to eat their meal did not always receive this assistance in a timely manner. There was a choice of fruit juices on offer but people were not always being offered water during the course of their meal.

People's opinions as to the quality and choice of food on offer, was mostly positive. However, we did hear complaints from three people regarding the food who told us that meals lacked nutritional goodness and that they wanted more fresh vegetables. We discussed these complaints with the home's head chef and the registered manager who told us they had begun a series of 'meet the chef' sessions where people were invited to make suggestions and discuss how mealtimes could be improved.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received training in mental health legislation which had covered aspects of the Mental Capacity Act (2005) and DoLS. People living in the home were able to access all parts of the building and/or leave the premises if and when they wished to. One member of staff told us, "We have to give people choices; we can not make them do things." Where people did not have the capacity to make decisions about their safe movement in and around the home and beyond, assessments had been undertaken and DoLS applications submitted to the relevant agencies. Staff understood the reasons for these decisions and their potential impact on people's freedom. The registered manager demonstrated a good understanding of mental capacity issues and was able to explain how people's capacity was tested and when testing should be carried out.

People's names were displayed on the doors to their rooms and rooms contained personal items which supported people's sense of identity and/or aided memory. In some areas, the provider had considered the design of the home in supporting the needs of people living there. Corridors in the dementia unit were hung with sensory pictures. There were photographs of staff working on the units posted on walls, although these probably needed to be placed lower down, be of a larger size and in colour to be of benefit to the people living in the home. Pictures of staff members who were no longer working in the home also needed to be removed and the registered manager told us that this would be done. One corridor on the dementia unit had been designed to represent a bus stop and seating area. We were told that bus timetables would be added and a sweet shop built so that people could visit the facility and purchase items. There were also plans to incorporate other thematic areas within the home such as a coffee shop with a seating area and a cinema.

Requires Improvement

# Is the service effective?

New staff were required to complete a 12 week induction which involved classroom and e-learning training sessions in areas such as fire safety, food hygiene and moving and handling techniques. We spoke with a new staff member in their first day on the job who told us, "I have been shown around the building, introduced to clients and I've read people's care plans. The place is pretty well organised, the staff are good, attentive and are doing their jobs diligently." We saw evidence that most staff had completed training in dementia awareness and that staff had either completed or were booked to do further training in subjects such as medicines management, safeguarding and equality and diversity.

Requires Improvement

# Is the service caring?

## Our findings

People told us staff were kind and caring. One person told us "The nurses are very caring and absolutely wonderful." Relatives described staff as "marvellous", "brilliant" and "amazing." One member of staff told us that the best bit about their job was the "special connections" they had built up with some of the people living in the home.

All the staff we spoke with were welcoming and courteous. We saw staff approach people with patience and kindness. Staff knocked on doors before entering and spoke to people in a pleasant and respectful manner. Staff offered people choices about activities and what they would like to eat and drink and gave people the time to decide and respond. For example, we saw the activities co-ordinator explaining what activities were on offer and asking people if they wished to take part. We also observed staff asking people what their food preferences were and exchanging these choices when people changed their minds.

However, despite the positive elements detailed above, we did not see staff asking or noting whether people were comfortable in their beds or when seated in the lounge areas. We did not see staff using talking mats or any other aids to promote communication. One relative told us "There's still not nearly enough communication with the residents. "Staff told us they relied on facial expressions to understand the needs of residents who were unable to communicate verbally. On more than one occasion we saw that people had slid down to the bottom of their beds and fallen asleep in chairs in awkward and uncomfortable positions likely to have compromised their comfort and mobility. At one point we noticed someone who was visibly distressed, red in the face, hot to touch and covered in a duvet whilst seated infront of a window exposed to full sunlight. This person was unable to communicate verbally or mobilise independently. We immediately asked a nurse to assess this person's welfare and saw that this person was quickly made more comfortable.

Care plans showed evidence that end of life decisions had been discussed with people when and where appropriate. However, we saw documents that indicated whether people wished attempts to be made to resuscitate them in the event of cardiac or respiratory arrest were not always fully completed, did not have a review date and had not been signed by anyone other than the visiting GP. This indicates that staff were not aware of or had failed to appreciate the importance of completing in full, documentation relating to end of life decisions. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were given choices about whether they wanted a male or female member of staff to care for them and this was documented in their care plans. Care plans did not however, contain sections to be completed about how people wished to dress, maintain their self-image and express their sexuality. Relatives told us that people's personal items sometimes went missing. We heard from relatives how two sets of their family member's dentures had disappeared. We also heard how people's clothes were mistakenly worn by others or were damaged in the laundering process. The registered manager told relatives that she would speak to staff about this matter and asked that lost items were reported directly to her so that she could take action.

We saw evidence that people were asked for their views about the care they received and how the service was run. We attended a relative's meeting which was chaired by the operations manager and the registered manager. The meeting was attended both by people living in the home and their family members. We noted that attendees did not have access to the minutes from the last meeting and had to request that previously discussed issues were addressed before moving on to the latest agenda. We asked to see a copy of the minutes from the previous meeting held 29 November 2014 and noted that it contained no action points despite the many suggestions and requests that had been made by relatives. Topics discussed at the meeting held during our visit included staffing levels, food choices, activities, safeguarding and the future refurbishment plans.

Relatives and friends told us they were able to visit their family members whenever they wished. Visitors could see people in their rooms or in the lounge areas and outside in the garden. Relatives told us they felt the garden area was underutilised. The registered manager told us there were plans to invite volunteers in to the home to overhaul the garden area and plant sensory herb and flower areas once the refurbishments on the ground floor had been completed.

Inadequate

# Is the service responsive?

## Our findings

Not all sections within people's care records had been fully completed and/or signed by the relevant parties and paper files were not always updated in a timely manner. We found conflicting information about people's allergies across the different filing systems. We also found information relating to people's pressure wounds poorly or incorrectly documented. For example; we noted that re-positioning charts recorded one person's skin integrity pressure points as being intact on the same date staff had also identified and recorded a grade 2 pressure wound. It was documented that this person was on an air mattress in order to minimise further skin damage but the type of mattress and the settings were not prescribed or checked on a regular basis. We found an undated photograph of this person's pressure wound in their care records. This indicated that staff were not monitoring and/or accurately recording information relating to changes in people's health and wellbeing. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Activities programmes were displayed around the home and we were told that people living in the home were given a copy of the activities programme prior to events taking place. We observed organised activities taking place during our visit which included cake baking and a famous faces guessing game. We did not see the sensory room in use or see any activities taking place on an individual basis on either of the days we visited the home. We noted that one to one activities and relaxation sessions in the sensory room had been scheduled for the beginning of the week and staff confirmed that these had taken place. People's activity diaries recorded whether they had been asked if they wished to join in with activities and what if any activity they had taken part in. Other activities included pet therapy, church services, exercise and music sessions.

Some people using the service told us they had little opportunity to access the local community and take part in activities such as going to the theatre and visiting museums and parks. One person said, "There is nothing to do. You can't go out. There is nothing to stretch your brain or your intelligence." The recently appointed activities co-ordinator told us they were building relationships with the residents to find out what they liked before organising visits to places of interest.

We saw copies of the complaints policy displayed within the home. The policy explained how to make a complaint and to whom. We saw that the provider had received and logged two written complaints since the last inspection in August 2014, both relating to standards of care and the skills of nursing staff. The registered manager told us that matters had been resolved following review meetings and changes to care plans. People's verbal complaints about food, missing personal items, lack of opportunities to access the community and staffing levels had not been recorded in the provider's log and so it was not clear what if any action had been taken in regards to these matters.

People living in the home and staff told us they didn't always feel they were being listened to when they made a complaint or raised a concern. One person told us "It's not often I complain. Nothing gets done, nothing is changed." Discussions with colleagues at Healthwatch Central West London, whose dignity champions visited the home in February 2015, also highlighted that some people did not feel readily able to make a complaint.

A suggestion's book was available in the reception area and we saw that comments had been made by visitors and family members in regards to staffing levels and cleanliness. No suggestions had been made by people living at the home and we did not see comment cards being made available to people on any of the units.

The registered manager told us that the annual customer survey had not been completed because there had not been enough responses from people living in the home. This and the above four paragraphs indicate that the provider was failing to provide opportunities, encouragement and support to people in relation to promoting their autonomy, independence and community involvement. The provider was also failing to assist people to express their views and, so far as appropriate and reasonably practicable, accommodate those views. This was therefore a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Requires Improvement

# Is the service well-led?

## Our findings

People were not always protected against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to regularly assess and monitor the quality of the service. We saw that quality monitoring was undertaken to assess compliance with local and national standards. Monthly audits looked at areas such as care plans and medicines administration. A visit by the operations manager in January 2015 highlighted the issue of incomplete fluid and food charts. Care plan audits from January 2015 and February 2015 also identified that people's fluid charts were not being fully completed. We identified similar shortfalls during our visit. This demonstrates that whilst audits are identifying areas that require improvement, recommendations are not always being actioned. This means that quality assurance procedures are failing to ensure people's health, safety and welfare is protected and promoted. This was a breach of Regulation10 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 service had a registered manager. The registered manager was responsible for the day to day management of the service and was supported in her role by an operations manager, a deputy manager and a clinical lead nurse.

From our discussions with members of staff it was evident that they held mixed views about the registered manager's approach to running the home. Some staff told us the manager was "supportive" whilst others told us "she's good in many ways but she's not always listening." Some of the relatives we spoke with also reflected this ambivalence in relation to how the home was managed with one relative telling us that there was "a low appreciation of what is required to ensure that a care home is a happy home: for that to occur both staff and resident's needs must be managed as they are interdependent."

The registered manager told us she was aware that not everyone was happy with the changes that had been implemented in order to bring about much needed improvements for people living in the home. This had involved changes to staffing and the departure of staff who had been underperforming. The registered manager told us the home now had "new, fresh, confident staff who want to work with us." She also told us about more robust policies and procedures that had been put in place around staff absences and about reductions in the use of agency staff. The registered manager reiterated that she operated an open door policy and was on call for any serious incident or emergency 24/7.

There were processes in place for reporting accidents and incidents. We saw that the service used an incident tracker to record details of all accidents and incidents. This logging system also provided a brief analysis of what action followed and whether the police and/or local authority had been informed of events. A safeguarding tracker was also in operation and provided a similar overview of concerns and listed recommendations and outcomes. We saw evidence that safeguarding issues, accidents and incidents were discussed at staff meetings and that further training, supervision and staff support was implemented to reduce the risks of similar incidents reoccurring.

The service had a whistleblowing policy dated July 2014 which provided staff with guidance on how to voice their concerns within the company they were employed by. The policy directed staff to agencies that could assist with independent advice and provided contact details for the Care Quality Commission and other relevant agencies.

The home worked closely with people's GPs, palliative nurses and clinicians from community mental health teams. The registered manager told us that they continued to collaborate with health and social care professionals and local authority staff and were "building and sustaining good relationships in the community."

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br><br>**The registered person had not so far as reasonably practicable ensured that service users and others were protected against the risks associated with unsafe management of medicines and the spread of infections.**<br><br>Regulation 12 (1) (a-i) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider was failing to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service users and of decisions taken in relation to the care and treatment provided. The provider was failing to assess, monitor and mitigate the risks relating to the health and welfare of service users which arise from carrying on the regulated activities.<br><br>Regulation 17 (1) (2) (a-f) |

**The enforcement action we took:**
We issued a warning notice.