Care Quality Commission

Sanctuary Care Limited

Bartley Green 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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This report provides details from two separate inspection visits which took place months apart. The first inspection visits were in February 2015 and the second inspection visit was in October 2015. We were unable to provide a report from our visits in February but felt it valuable to provide summaries of both visits together with the judgements from the most recent inspection visit in October 2015. Both visits were unannounced. Prior to the February 2015 visits we had last inspected this service in October 2013 where we judged that the service was compliant with regulations.

Bartley Green Lodge provides accommodation with care and support for up to 47 older people who live with dementia. At the time of our visit in October 2015, 43 people were using the service.

There was a registered manager in place on both of our visits but the registered manager had changed between our February visits and our visit in October 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 both our February visits and at our October 2015 visit we found that people were not having their medicines administered, stored or accounted for properly. We found that some people were not receiving their medicines as prescribed. Arrangements for administration of some medications was not safe. The overall management of medication was not meeting the legal requirements and you can see what action we told the provider to take at the back of the full version of the report.

We told the provider following our visits in February 2015 about our concerns about how the systems in place had failed to identify areas where the home needed to improve. At that time we had evidence that there had been changes in both management, increased training and changes to the monitoring systems but this had failed to ensure that improvements were made quickly. At our visit in October 2015 we found that checking, monitoring and audit systems had not sufficiently improved to ensure that ongoing failures, deficits or inadequacies were identified and acted on in line with requirements of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

Staff knew how to recognise signs of abuse and who to raise concerns with. People had assessments which identified actions staff needed to take to protect people from risks associated with their specific conditions, although these were not always sufficiently revised following changes in people's health or risks to them.

In February 2015 people were not supported by appropriate numbers of staff to meet their health and social care needs. At that time the provider had not ensured that the staffing levels reflected the support people needed. Following this visit several people who had complex care and nursing needs had moved from the home to other services. When we visited in October there were enough staff to meet people's needs

There were robust recruitment and induction processes in place to ensure new members of staff were suitable to support the people who lived in the home.

Staff we spoke with had knowledge about the people and their health needs. Staff told us that they had received training however this did not always result in staff being competent to ensure that people received the care outlined in their care plan.

The registered manager and staff we spoke with were knowledgeable of the requirements of the Mental Capacity Act 2005. In February we found that staff did not support people with their personal care if they did not consent . However this had resulted in some people not having support with their personal care for long periods and records about whether people had effectively attended to their own personal care were not clear. Steps had not been taken to look at ways in which people's capacity to accept care could be improved. In October 2015 we saw that this had improved and observed how people were encouraged to consent.

People who did not need support to eat and drink were offered choice of suitable food in a calm atmosphere and improvements had been made to enable people to have drinks more easily. We found in October 2015 that people who needed support to eat and drink enough to maintain good health were not receiving the support they required.

People told us they were happy with the care staff. Staff spoke in appropriate ways about people who they supported. At times the care provided was task centred and this meant people did not get the support they requested. Staff knew how to maintain people's privacy and dignity when delivering personal care.

There had been some improvements to the amount of activities that people were offered between the February visit and the visit in October 2015. However, people were not always offered the activities that were advertised as available within the home. Improvements had been made so that people who liked to walk around the home had a few things that they could pick up and look at and one or two people had items reflecting their previous interests and hobbies. Improvements had been made to the recording of concerns, complaints and compliments, and these were managed appropriately.

The new registered manager of the home was viewed positively by people who visited the home. Relatives and some staff told us of the improvements that the

Summary of findings

registered manager had made to the home. Relatives told us that the registered manager listened and two staff told us that the registered manager supported staff on the units when the home became busy.

We met with the provider following our October 2015 visit and they told us of actions that they had taken and were continuing to take to improve outcomes for people an ensure that people were provided with a service that met their needs at all times.

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 always safe

Medicines were not always administered as prescribed and checks of medicines were not always robust enough to identify errors putting people at risk of harm.

The provider had taken appropriate action when safeguarding issues had been identified. Known risks to people were not always adequately reviewed to help people safe..

Staff were recruited appropriately and the numbers of staff deployed were meetings people's needs.

Is the service effective?

Requires improvement

The service was not always effective

Although the provider had provided staff with training this had not always ensured that people had the care and support they needed with management of their medicines and with their diet.

People told us that they enjoyed their food but some people were not always receiving support they needed to eat suitable food.

People had access to health professionals however records of the outcomes of these consultations were not always readily available.

Is the service caring?

Good

The service was caring.

Staff knew the people they were supporting and were kind in their interactions.

Staff knew how to support people's dignity and took action when there was a risk that people's privacy would be compromised.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Although the service had started to improve in ensuring there were events or items to occupy people, further were needed.

People had individualised care plans but these were not always changed when people's health changed.

Summary of findings

People were supported to raise concerns and complaints and these were managed appropriately.

Is the service well-led?
The service was not well-led.

The provider had not ensured that there were effective systems in place to identify and manage risks to people. Audit systems had not been effective in ensuring that people received good quality care and support.

People who used the service, their relatives and some staff expressed confidence in the changes being introduced by the management team.

Requires improvement

Bartley Green 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.

Our last inspection took place in October 2013 when the service met the regulations that we inspected. This inspection took place over three unannounced visits. The first visits were on 3 and 5 February 2015 and the second visit on 19 October 2015. We were unable to provide a report from the first visits in February but felt it valuable to provide summaries of these visits together with the judgements from the second inspection visit in October.

The inspection team in February 2015 included three 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. This expert-by-experience had experience of services providing support to older people. Our visit in October 2015 included two inspectors, a pharmacist inspector and another expert by experience.

We reviewed all of the information we held about the home. This included statutory notifications received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law. Before we returned for our second visit in October 2015, we reviewed the information we had obtained at our first visits in February and we spoke with the local authority who commissioned services at the home. This helped us to identify if the provider had taken action in response to feedback given at our first visit.

During the February inspection visits we spoke with 20 people who lived in the home; some from each of the three floors of the home. We spoke with the relatives of ten people, two visiting health professionals, ten care staff and the then registered manager. On the visit in October 2015 we spoke with 11 people who lived in the home and 10 relatives and received information from a relative following our visit. We spoke with seven staff and the registered manager. The area manager was also present for part of the visits. During all our visits we observed how staff supported people, spending time in all of the communal lounge and dining areas in the home. On our visit in October 2015 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.

In February we looked at some parts of eight people's care records to check how their care was provided. We looked at the records of four people's medication administration records. We looked at computerised training records and three staff recruitment files. At our visit in October 2015 we looked at parts of another three care records, 12 medication records and viewed complaint, accident and incident records. In addition we looked at records of the monitoring checks that managers made to see how they ensured the service was safe and continually improving.

Requires improvement

Is the service safe?

Our findings

At our visit in February and October 2015 we saw that staff who administered medicines did so in a kind way and people were appreciative of this. However, the administration of medicines was not safe. We had been approached by visitors in February who were concerned that their relatives had not been given their prescribed medicines.

Our visits in February 2015 found that people's medicine had not always been re-ordered in a timely way; so some people did not have the pain relief medicine they needed and one person was administered medicine that was had passed its expiry date. People had not always received medicines at the time prescribed. Where people had refused medicines there had been little investigation to see if it was still required or any action taken to see if people could be encouraged to take their medicines more regularly. We had found that there was a significant amount of medicine that needed to be returned to the pharmacy to be destroyed and there had been no safe accounting of these medicines. There had not been enough safeguards where a decision had been made that a person's medicines should be disguised in food. The counts of medicines and the records had not matched so we were not confident that people had received their medicines as indicated in the records. Systems for checking the administration of medicines had not found these errors even though these failings had been of concern when a visiting pharmacist had undertaken their checks three months before our February visit. We advised the provider of our concerns during this visit.

At our visit in October 2015 some of our concerns about management of medication for people remained. Despite the provider supplying evidence of training and additional monitoring of medicines between the February and October visits we found that people's medical conditions were not always being treated appropriately by the use of their medicines. For example, three people who had been prescribed inhaled medicines were not receiving the dose that had been prescribed and recorded as given. One person had been prescribed an antibiotic which needed to be administered on an empty stomach and staff were not aware of this. The person was receiving this with or just after their meals, which meant the antibiotic would not work properly. Another person's records showed that they had not received the correct doses of their regular medicines to control their anxieties and as a consequence the staff were regularly using a 'when required' medicine which should have only been needed occasionally.

When we checked some records we found gaps in the records which indicated that these medicines had not been administered; there was no reason given as to why they had not been administered. Some people who had pain relieving patches were not having these applied in accordance with the manufacturer's guidelines and not always as prescribed. This could mean that people experienced more pain than they needed to. We continued to find that there were inadequate safeguards where medicines were being disguised in food and drink. There was no evidence of guidance for staff or checks on the safety of mixing drinks with the medicine, and no records that confirmed the agreement that administering medicines mixed in drinks was in the person's best interest.

In October 2015 we observed the refrigerator temperature records. We found that the maximum and minimum temperatures of the refrigerator were not being monitored on a daily basis and where the temperatures had been recorded higher than needed this did not result in staff taking action. The refrigerator was storing temperature sensitive medicines and as a consequence of these temperature records the provider was advised by the pharmacist inspector to discard some of their current stock of certain medicines.

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

Following the October 2015 visit the provider met with us and outlined assured us they were taking action that had been taken to ensure safe administration of medicine including: limiting the number of staff who administer medication and these staff were not undertaking other care tasks. All other staff with this responsibility had been stopped from undertaking medicine administration until they had been assessed and found to be competent. Further checks were being undertaken to ensure that any errors could be identified more quickly and put right. They advised that more detailed checks were to be made to include inhalers and liquid medicines.

Before our visit in February 2015 several concerns were raised with us about the safety and care provided to people living in the home. We found that there were significant

Requires improvement

Is the service safe?

concerns about how people were cared for and we advised the local safeguarding authority. Following discussion with the provider about our visits the incidents of safeguarding concerns lessened.

In October 2015 people told us they felt safe in the home. Visitors told us that their relatives were safe from abuse. Staff were able to tell us about the signs that may show that people were being abused and who they would report any concerns to within the home. Staff knew the agencies involved in safeguarding people from abuse that they could contact if they were unhappy with the response of the provider to any raised concerns. They told us that they had training about safeguarding and maintaining the safety of people. We saw that information was available about safeguarding displayed in the office.

Prior to the October 2015 visit there had been a fire in the home where the safety of people could have been compromised. However, once the fire had been identified, staff had acted promptly, and as they had been trained, to keep people immediately safe. The registered manager and provider made arrangements to ensure that all people affected had appropriate accommodation and care during this disruption. The cause of the fire remained under investigation at the point of writing this report. The provider confirmed that they had taken extra measures to monitor people's safety from fire and ensured that staff remain competent in their response times to drills. The provider had taken reasonable steps to respond to any individual safeguarding concerns raised.

In February we found that the systems to assess and manage risks to people living in the home were not being applied sufficiently well to ensure the safety of people in their care. At that time visiting health professionals had concerns about people who had injuries to their skin and relatives told us about their concerns and views that people needed more intensive support. We found that risks that had been identified with people's skin and nutrition had not resulted in planning to minimise the risk to their well-being. We spoke with the provider about this.

In October 2015 we looked at some care records for people who had additional support needs. We found risk management plans had been put in place to tell staff what they needed to do. However, reviews did not always accurately reflect changes to the level of risk or result in changes to plans. For example, the description of one person's skin was described as healthy however when we observed that the person we saw that they had two separate injuries to their legs and later was described as having tissue paper skin. We looked at some people's recorded accidents and incidents and found that the provider's expected system was not always adhered to and this meant that people's risk reviews had not been taken into account and were inaccurate. We spoke with the provider following this inspection who told us that they had introduced a documented method of monitoring accidents and incidents so that these could more easily be used when reviewing people's risks.

In February we looked at the staff recruitment files for three recently recruited staff and found that staff had the appropriate checks before they started work. There was evidence of application forms, references, checks with the Disclosure and Barring Service (formerly the Criminal Records Bureau) and copies of any previously acquired relevant social care qualifications. Records of these staff showed that they had experience of supporting people with personal care. The provider had made appropriate checks to ensure that staff were safe and experienced to work in a care home.

Throughout both our visits people who used the service told us that there were enough staff to meet their needs. Comments made included: "[Staff were] Always available and always ask how you are" and "Staff have the time to do what they need to do." A person commented: "I can walk about and feel safe" and "I'm happy… no worries." In February we saw that staff were busy throughout the day and at times staff were not available to monitor people in lounges because they were supporting people with personal care. Senior care staff told us that were administering medicines later than prescribed because they were supporting staff to provide personal care. Some relatives and staff told us there were not enough staff on duty to meet some people's complex needs and to keep people's bedroom areas clean. Health professionals told us that some staff were more organised than others because people were ready to receive their planned treatment. We saw bedrooms that were not clean and some areas of the home had lingering unpleasant odours. We found that there was not enough staff to ensure that people's needs were met and to attend to the cleaning and laundry needed in the home.

In October 2015 we saw that there were more available staff in the lounges, which we were informed was as a

Requires improvement

Is the service safe?

result of fewer people needing intensive care and support from staff. We saw that where people needed assistance with personal care this was attended to more quickly than it had been at previous visits. A supervising member of staff was available in the lounges to attend to people's needs except on occasions on the ground floor. A relative told us that they had concerns during the summer months between our visits about the numbers of agency staff especially at the weekend but told us that they thought this was now getting better. We saw that the cleanliness of the home had improved. We were informed and given evidence of care and domestic staff that had been recruited and were awaiting final checks before being employed so that they could further improve staffing levels in the home.

Requires improvement

Is the service effective?

Our findings

At our visits in February 2015 staff we spoke with were experienced in providing care and supporting people. A member of staff told us that before starting work at the home they had spent a week learning about how to care for people for example in how to use hoists and how to protect people and themselves if people became distressed. Staff had knowledge of people's life histories and were aware of most people's health conditions. Staff we spoke with told us that there were lots of e-learning courses that they were undertaking to ensure that their training was refreshed. We observed that at times there were not enough staff trained in medicine administration to cover the night shift and this meant that staff on day shifts had to stay longer to provide this support before they went off duty. Staff indicated that they wanted more guidance on strategies and support they could use for working with people who could become upset when needing support with personal care.

In February staff told us they had supervision meetings and had team meetings but did not feel their concerns were addressed. In October senior staff advised that they had not had senior staff meetings recently but were aware that this was about to change.

Further training was given to key staff following our visits in February in areas where we found shortfalls however we found this had not ensured that staff's competency in medicine administration had been sustained.

At both the visits in February and in October 2015 people told us that they liked the meals provided. Their comments included: "The food is very good," "I always enjoy the food" and "The food is good I always finish it."

Following our visit in February 2015 we told the provider that improvements were needed to meet the needs of people who required: soft diets, culturally appropriate diets and / or required support to eat. Following our February visits the provider assured us that they were taking action to ensure that staff had necessary knowledge of and would adhere to plans to meet people's support needs and special diets.

At our October 2015 we found that this issue had not been fully addressed. We found that although the provider had supplied training staff were not ensuring that, where assessed, people had an appropriate soft diet. For example records showed that people who were assessed as needing a soft diet were being offered biscuits and sandwiches and when a senior staff member was questioned about the safety and suitability of doing this they did not see this as a problem. We also saw that a person who had remained in their bedroom was left with their lunch in front of them, throughout the lunchtime period, appropriate support was not offered or provided. At times throughout the day people were not reminded to drink and their hot beverages became cold. A statement about the amount of fluid all people needed per kilogram of their weight was recorded. However the amount each individual person needed per day had not been calculated. When we asked what the amount would be healthy for one person the staff member did not know but gave a lower amount than would be recommended for the majority of people in the home. The person had an identified risk of becoming dehydrated and their fluid records indicated some very low levels of fluid intake without any identified action being taken and lower than their calculated intake should be. Some people were not receiving the support they needed to have adequate amounts of suitable, nutritious food and adequate levels of fluid. The registered manager told us that training was being arranged for the chefs to be taught some appropriate cultural diets.

During both February and October visits we saw that people had a choice of when and where they had their breakfast. In October 2015 we saw an improvement in how often people were offered drinks throughout the day and saw that people were being helped to retain skills and independence by jugs and teapots being available so they could serve themselves. The meal time experience for people was generally calmer; people who were in the dining and lounge area for their meal were supported appropriately to remain in the area so that they had enough to eat and drink to maintain their health.

We saw records that the registered manager was ensuring that people's weights were being monitored on a weekly basis to ensure that meals provided were sufficient to meet their needs. This was an improvement to our visit in February.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people

Requires improvement

Is the service effective?

make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA, Deprivation of Liberty Safeguards (DoLS). The provider had submitted some DoLS applications to the local supervisory body for authorisation where these applications were waiting to be assessed. These applications were where people were deemed not to have capacity and wanted to leave the home and where people refused personal care. At the time of the inspection in October 2015 these applications had not yet been assessed by the local authority so had not been authorised.

In February some visitors told us of their concerns about relatives, who lacked capacity, not having support with their personal care because staff said it was the person's choice. We had observed some people who at times were inappropriately dressed and needed support with personal care were not attended to by staff. In October 2015 we found there had been improvements and that people were being supported to attend to their personal care more regularly and this showed that the provider and staff were trying to improve people's capacity to accept appropriate care.

Staff told us they had received training in the MCA and Deprivation of Liberty Safeguards when we spoke with them they had an understanding that there was legislation about this. Although people had access to the different floors of the home going out of the home was restricted and for people's safety the front door was locked. We asked about people's access to going outside and could find no records of the home supporting opportunities for people to go out.

During our visits in February 2015 two visitors told us that some health tests had been requested by health professionals and they had not been told of the outcome of these tests. We could find no record of the tests and outcomes and the deputy manager could not tell us if the appropriate samples had been taken. Health professionals raised concerns about the number of people needing nursing support to meet their needs. This included an increase in the number of people who needed support due to moisture damaged skin and required support to move with hoists. The health care professionals told us that they did not believe that there were enough staff to give appropriate care to people with increased health needs.

In October 2015 we found that there were fewer people who needed nursing care being supported in this home. A further two people had recently been assessed as requiring the support offered in a nursing home. We spoke with two visiting health professionals who told us that they had no concerns about the care of any specific person in the home and they commented this was an improvement since February. However they told us that some staff groups or shifts were more organised than others in supporting health colleagues for people's known treatments. During our October 2015 visit we found that records indicated that people had health appointments but the outcome of these consultations were not always recorded well within the care plan although information was found, this could mean that up to date information about people's health conditions and their management could be lost.

Good

Is the service caring?

Our findings

In February and October 2015 people we spoke with told us that staff were caring. Their comments included: "[Staff are] Very good. They ask if you feel well in the morning," "All the staff are polite" and "They are very helpful."

We spoke with some relatives in February who had differing experiences of members of staff. Some had found that staff were caring and supporting but other relatives had told us that it depended on which staff were on duty and reported to us incidents where individual staff displayed uncaring attitudes to relatives or people with high support needs. In October we found that more relatives we spoke with were happy with their contact with staff. For example two relatives told us: "The staff are friendly and kind," and "The staff are kind, nothing is too much trouble." One visitor told us although communication could improve they were sure that staff were kind and considerate to their relative.

In February we found that staff's ability to communicate with people taking into account their needs varied. For example we saw some staff making sure that they communicated with people when they were at eye level, holding people's hands, speaking with an appropriate tone of voice and taking time when they were assisting a person to make choices. In October we found that staff were much more available to provide prompt care. Staff showed kindness and were mostly responsive to the needs of people however we saw staff ignoring one person when they asked for a menu and our request for a copy of the menu was not responded to either. Although some staff interactions with people were task focused generally staff supported people. For example we saw staff ignoring one person when they asked for a menu and our request for a copy of the menu was not responded to either. This incident of ignoring a person was brought to the attention of the registered manager who undertook to address it.

In February we saw some people who were living with dementia had been refusing personal care and support and this, at times, had compromised their dignity. We checked the care records of people who were refusing personal care and found that their assessment at the time of admission had determined that they did not have sufficient capacity to understand the impact of their decision to refuse assistance. We did not find any written guidance or plans to assist staff to try and lessen the number of times people refused. We spoke with staff about this and they were able to tell us what had and had not worked but there was no system to ensure that staff built on the success of an approach that had worked.

In October we saw an improvement in people's appearance and it was clear that staff were supporting people more effectively. For example we saw that where people had dressed inappropriately or when they had food spilled on their clothes people were supported in a kind way to see the problem and supported to be dressed more comfortably. We saw the registered manager of the home demonstrating and modelling good interactions with individual people who were living with dementia and were wanting some time. For example, we saw people accompanying the registered manager whilst she was undertaking tasks and that she took time to speak with people.

During both visits we saw occasions where people who lived in the home infringed on the privacy of other people. However we saw that people had access to their bedrooms when they wanted and there were other rooms other the main lounge / dining area where people could go to if they wished to have quiet time. We saw that staff knocked on doors and waited for an answer before going in. Staff sought agreement of one person before going into the person's room to look for an item they had requested. Staff we spoke with were able to tell us how they preserved people's privacy and dignity when providing personal care.

Requires improvement

Is the service responsive?

Our findings

In February we found that not all care records we looked at showed that an assessment had been completed before people were admitted to the home. For one person an assessment of the person's needs that had been undertaken at the provider's sister home had not been updated or reviewed to take in account the new environment or the potential interactions with the existing people in the home.

The home had documents to be completed with people or their relatives called 'This is me' so that people could have an opportunity to say what was important to them. This documents also had space to record information about people's life history, culture and interests. These were not always completed and there was little evidence that the information in those that were complete had resulted in care that was individual to the person. In October 2015 we found that care plans had been reviewed, records were more organised and where there had been gaps in records about people's culture history and interests these had been completed. We were told about imminent training so that more appropriate foods reflecting people's culture could be supplied on site. In addition we saw that people had appropriate creams to apply to their skin if needed.

The reviews we looked at had not taken into account accidents or changes in people's health conditions. For example, we observed that one person had both of their legs had been bandaged and that they were wearing tight 'pop socks' over the bandages which were causing indentations to their legs putting their skin integrity at risk. When we looked at their records, it was clear that health professionals were seeing the person and providing treatment. The person had an accident which resulted in an injury this had not been taken into account on the review and their care plan remained the same despite the additional risks to person's skin, appetite or mobility.

When we asked people in February how they spent their time. People's comments included: "I would like to see a social room where you're doing something instead of just watching TV. It would be good if we could do some exercise, flower arranging, bingo or even art activities," "There are no purposeful activities… [I] like to go to different places… I feel I'm just wasting time everything is repetitive" and "There is not a lot to do." This was confirmed by relatives that we spoke with.

At our visit in October 2015 we found that although there had been an activity co-ordinator recruited since February this member of staff had left. One person told us: "They [the activities} have started to get going." The majority of relatives told us that there were more activities taking place. We saw that there had been action taken to provide more items for people who like to walk around the units to take interest in. However we observed that staff did not always ensure that activities took place as they were advertised.

Visitors told us that they could visit their relatives when they wanted and we saw that visitors were in the building throughout the day and evening on all of our visits. We saw a person being assisted to use a telephone in the dining area. People were supported to keep in touch with people who were important to them.

In February relatives told us that they had complained about the cleanliness of the home, items going missing and the attitude of some staff when they raised their concerns. We found that records of complaints had not been maintained and that the then management of the home was not able to provide any confirmation or evidence to indicate that more than one complaint had been received although relatives had told us they had complained. There was no evidence that the one complaint had been considered or responded to. This complaint had not been reported to the provider of the service as their internal process required. We found a record in hand-over notes that another relative was not happy with the service; the record did not give any detail of the concern or how it was resolved, we could find no other reference to this concern. There was a lack of response to issues that were raised with staff and managers.

At our visit in October 2015 we found improvements had been made. There was information about how to complain and how to make improvement suggestions displayed in the home. We saw that the new registered manager had records of the complaints they had received during her time and these records showed that they had been investigated and responded to in a timely way. Where shortfalls had been identified the registered manager had apologised for the shortfall. We saw that the home had received compliments about the environment of the home including the cleanliness and changes including having a shop and the hairdressing room on site.

Requires improvement

Is the service well-led?

Our findings

People who used the service were unable to give us an opinion about the management of the home. In February, relatives we spoke with had differing views about the effectiveness of the management. Some relatives were unhappy about how situations were managed their comments included: "I feel let down. The manager promised [an activity for my relative]. It has not happened," and "I do not understand why my relative has to go to hospital when a dressing falls off." Other relatives we spoke with were happy with the personal care people received but told us that there were not enough activities provided or time for staff to engage with people. They also told us that the effectiveness of the laundry needed to be improved. One relative told us: "The management need to listen to what we are saying." Staff told us their opinion about people's care and staffing levels was not taken into account and that the management rarely assisted when staff on the units became busy.

The provider had ensured that a who understood their responsibilities was registered with CQC in a timely way following the departure of the previous registered manager from this service. In October 2015 we saw that the management were more involved with the people that lived in the home. The relatives we spoke with were more positive about the new management of the home. Comments included: "You can talk to her [the new registered manager]…she was very good with [my relative]" and "Nothing is too much trouble for the new manager….the manager has raised the game and staff have responded well." Some staff told us that the new registered manager and new deputy were more likely to assist if needed and saw benefits in how staff were expected to work for people who lived in the home. Other staff told us that more staff were needed. There was evidence that staff were not acting as they had been trained in respect of record keeping and medication administration. The management told us that some staff were disrupting changes making it hard to change the culture of the home quickly. A visitor told us that some staff did not take responsibility to be able to feedback to relatives about the health and well-being of a loved one.

In February the system for monitoring concerns and complaints was not managed well. Opportunities to review and learn from complaints and concerns that were being raised were not available to the provider because these views were not being collected. The provider advised us following that inspection of action that they were taking to ensure all concerns would be recorded and responded to and this was being done when we visited in October 2015. We saw that meetings had been arranged with relatives more regularly and solutions to longstanding issues were being discussed and relatives were being advised of changes and how they could assist with improvements.

In February and again in October the systems in place to monitor the care and support provided to people and to identify and take action to reduce risks were not effective. There had been failures in the care provided to people that had not been identified by the monitoring arrangements within the home. Systems to monitor risks associated with medication administration and audits of medication had failed to address the issues identified in November 2014 when a pharmacist visited the home to check the medicines and our concerns in February 2015. Systems failed to ensure that people had the special diets they were assessed as needing.

In February there had been a lack of management assessment of the impact of people's increased needs on: the care staffing levels of the home, deployment of staff and the arrangements for the cleaning in the home. Although this was found to be improving in October this was because the accumulated support people needed had lessened. Arrangements were not in place to ensure that staffing levels and deployment of staff were responsive to the changing needs of people.

Systems in place to check and monitor the quality of recording systems and training supplied in the home were not yet effective. Although the provider had taken action after the February visit this had not resulted in better outcomes for people.

There was lack of effective oversight by the provider which resulted in them not learning from people's experiences, not managing identified risks and not providing a service that was continually improving.

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

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment You were not ensuring the safe care and treatment for service users as there was not the proper and safe management of medicines. 12(1), 12(2)(g)

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance You did not have systems that were effectively operated to assess, monitor and mitigate the risks to health, safety and welfare of service users which arose from carrying out the regulated activity. 17(1) 17(2)(b)