Greensleeves Homes Trust

Grosvenor House

Inspection report

11-14 Grosvenor Gardens
St Leonards-on-Sea
East Sussex
TN38 0AE

Tel: 01424423831
Website: www.greensleeves.org.uk

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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**

Summary of findings

Overall summary

We last inspected this service in April 2015 where we found a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider submitted an action plan identifying how and when they would make the improvements. As a result we undertook this inspection on the 22 and 25 July 2016 to follow up on whether the required actions had been taken. We found these improvements had not been made and we found further breaches in Regulation.

Grosvenor House provides accommodation and care for up to 33 people, respite care is also offered. On the day of our inspection 29 older people were living at the home. The service provided care and support to older people living with diabetes, sensory impairment, risk of falls and long term healthcare needs.

The service had an acting manager in place who had been in post approaching three months. They were in the process of registering with the Care Quality Commission (CQC). 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 and associated Regulations about how the service is run.

We found people were not always being kept safe as the provider had not ensured risks were being managed appropriately in relation to areas such as accidents, outings and eating. We found not all aspects of security had been considered by the provider in relation to visitors' access to the home.

The administration of medicines was seen to be safe and people told us they received their medicines promptly and correctly. However the provider did not have clear systems in place to guide and support staff with 'as required' PRN medicines.

The provider had not consistently sought guidance from appropriate health care professionals in regard to people's health to ensure they were supporting them effectively.

Although sufficient numbers of staff were available to support people, we found the provider had not assured themselves of the suitability of a member of staff by making appropriate checks. Some staff had not been effectively supported through an induction when they began working for the provider.

The provider had not taken steps to ensure all people's care plans, particular those on respite had clear person centred guidance for staff on how to meet their needs and respond and manage people's behaviours. The provider had not ensured people's social needs were consistently met, particularly those who chose or were unable to leave their rooms.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the manager understood when an application should be made and how to submit one. Where people lacked the mental capacity to make specific decisions the home was guided by the

principles of the Mental Capacity Act 2005 (MCA) however care plans did not consistently reflect how decisions made in people's best interest had been reached.

Although the provider had some quality assurance systems in place these had not been effective at identifying the shortfalls we found; such as with regard to the oversight of accidents and incidents.

Training records confirmed staff members had access to a range of training that was suitable to ensure they had the skills and knowledge to support people that lived at the service.

Suitable checks were routinely undertaken to ensure the safe management of the building and environment including areas such as boiler and electrical systems.

The provider had established systems to enable people and their relatives to feedback their opinions on the quality of the service.

People were positive about the staff that cared for them. It was evident staff had spent time with people, getting to know them and building rapport with them.

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.

We found a range of risks were not being appropriately managed in relation to peoples care and support needs.

Risks related to access to the home via the front door had not been adequately assessed.

The provider had carried not carried out checks on a staff member to ensure they were suitable and safe to work with people.

Medicines were managed safely however staffs recording of the reasons why people needed 'as required' medicines was not consistent.

There were sufficient staff on duty to safely meet the needs of people.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the service had not consistently sought appropriate professional health care advice when support people to maintain good health.

Some staff had not been effectively supported when they started work for the provider.

Staff had an understanding of the Mental Capacity Act 2005 and consent issues, however best interest decisions were not being routinely evidenced.

People enjoyed meals times and the food however consistent systems were not in place to ensure all food was served hot.

A suitable training programme for staff had been established and was being delivered.

Is the service caring?

Good

The service was seen to be caring.

We saw kind and compassionate interactions between people and staff.

Relatives and friends told us they were unrestricted as to when they able to visit people.

Care records were maintained safely and people's information kept confidentially.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

A person's important wishes had not been respected.

Although the provider had a complaints policy and procedure this had not been consistently followed.

Care plans were not consistently providing clear guidance for staff on how to respond and support people.

People a range of recreational activities were available however we found occasions where people were who remained in there room had limited interaction.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

The provider had not assured the acting manager was effectively supported when they started their role.

Although there were some systems in place to assess quality these had not always been effective at providing clear oversight of the service.

We found examples where people's care records were not accurate or up-to-date.

People and staff spoke positively about the provider's new acting manager.

Grosvenor House

Detailed findings

Background to this inspection

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

We inspected the service on the 22 and 25 July 2016. This was an unannounced inspection. The inspection team consisted of two inspectors.

We reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records at the home. These included four staff files which contained staff recruitment, training and supervision records. Also, medicine records, complaints, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained information about their care and treatment at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we spoke with 12 people, two people's visitors to seek their views and experiences of the services provided at Grosvenor House. We also spoke with the acting manager and their deputy and eight staff. On this occasion we had not requested a provider information return (PIR) from the provider.

We observed the care which was delivered in communal areas to get a view of the care and support

provided across all areas. This included the lunchtime meals. As some people used non-verbal communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were unable to talk to us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2015 we found people's medicine administration records (MAR) charts were not being completed consistently when staff had supported them with prescribed creams. At this inspection we found this had improved.
However, at this inspection we found new areas where the provider had not taken adequate steps to keep people safe and mitigate risks. For example, accident and incident records identified one person had recently seriously choked on their food. Staff had not been able to establish a reason for this. A referral to this person's GP to request an assessment by a speech and language therapist (SALT) did not happen until over a month after the incident. At this inspection, the person was still being offered the same food and there was no evidence the provider had taken preventative measures in the interim, such as ensuring they received support from staff at meal times. This incident was not referred to in this person's care plan so staff may not know this person was at increased risk of choking.

Another person had fallen four times in a six week period. They did not have a mobility risk assessment to inform staff on how to support this person to remain safe. Records identified most of these falls occurred whilst this person was in their room however there was no evidence to indicate how staff had attempted to mitigate their risk of falling. For example by the use of movement sensor equipment. This same person had sustained a head injury in November 2015; however neither care plan nor accident records identified what follow up actions staff had taken at the time to mitigate the risk of a head injury such as regular checks or seeking further health care professional advice. This person had previously been referred to and discharged from the falls prevention team, however following our inspection the acting manager told us a further referral had been made.

On the first day of our inspection a group of people had chosen to go on an organised day trip to a nearby coastal resort. This had been planned and organised by the home's activity co-ordinator. However there had been no risk assessment undertaken for the event. This meant the provider was unable to demonstrate what steps they had taken to mitigate any potential hazards involved in taking people out on a trip who were living with a range of physical and health support needs.
The provider was unable to demonstrate what steps they had taken to mitigate any potential hazards and this was a breach of the Health and Social Care Act 2008 Regulation 12 (Regulated Activities) Regulations 2014.

The home's main entrance was accessed by automatic sliding doors. To get in or out of these doors an entry code was required. The acting manager told us some people's relatives had been provided with the door code. The provider had not taken steps to assess the risks associated with this. This meant a visiting relative could be followed into the home by someone who did not have permission to be there and may not be challenged by staff. There was also a risk that visitors may fail to sign in or out of the visitor book and if an emergency evacuation was required, staff and emergency services could not be assured who was in the service. We raised this issue with the acting manager who told us only a 'handful' of relatives had been provided with the access code but was unable to identify who they were. The acting manager informed us during the inspection they had drafted a letter to send out to all people's relatives informing them they

would be changing the door code and staff would be required to open the doors for all visitors.

The provider had not ensured that the risks associated with the security of premises had been managed and is a breach of the Health and Social Care Act 2008 Regulation 15 (Regulated Activities) Regulations 2014.

The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions which help prevent unsuitable people from working with people who use care services. We found a member of staff who undertook non care related work at the service did not have a DBS check in place. There had been no assessment undertaken to mitigate the risks of this person working without a DBS check. This staff member had unsupervised access to all areas of the service and therefore required a DBS. The provider gave assurances that a DBS check would be completed immediately.

People commented they received their medicines on time. One person told us, "I always get my pills on time; they (the staff) are very good." However we identified some issues with the management of medicines. Some people living at Grosvenor House had been prescribed PRN 'as required' medicines. These are medicines which may only be required occasionally such as for the relief of pain. The provider did not have PRN guidance or protocols in place to support staff with the management of these medicines. Protocols provide clear guidelines as to when people may require PRN and identify visual cues for those people who do not verbally communicate. Other information may relate to providing information as to when a person may require a higher or lower dose. Staff were not consistently recording on people's care documentation as to why PRN had been given. It is good practice to record the specific reason PRN medicines is provided so as any potential patterns can be identified and investigated.
We recommend the provider seeks best practice guidance related to PRN medicines from the NICE guidelines.

However we found other aspects related to medicines were managed well. For example we observed medicines being administered. The care staff gave the medicines and checked and double checked at each step of the administration process. Staff also checked with each person that they wanted to receive their medicines. Medicines were ordered correctly and in a timely manner that ensured they were given as prescribed. Medicines which were out of date or no longer needed were disposed of appropriately.

Care staff were able to identify their responsibilities to keep people safe from harm or abuse. They had a clear understanding of the different types of abuse. Care staff told us they had confidence senior staff would take appropriate action if they raised concerns relating to potential abuse. One member of care staff told us, "I know they (senior staff) would take any worries seriously." Care staff told us if they were not satisfied with the response from senior staff they would refer issues to the local authority or the CQC.

People told us there were sufficient staff available to assist them. One said, "Staff are here the whole time". If I have a problem I'll press my bell." A relative said, "There are always staff about, never noticed any issues with this." During our inspection staffing levels matched what was planned on the staff rota. During the night there were three care staff on the premises. The acting manager predominately worked in an administrative function and was based in their office; however staff told us they were visible throughout the day. Staff told us they felt there were adequate numbers of staff to keep people safe.

Suitable checks had been undertaken to ensure the safe routine management of the building and environment including areas such as electrical systems and legionella. Maintenance and servicing of equipment such as fire alarm, portable appliance testing (PAT) and boiler were seen to be routinely undertaken. Staff were clear on how to raise issues regarding maintenance. One member of staff told us, "Things will get fixed quickly once reported."

Requires Improvement

Is the service effective?

Our findings

At the last inspection in April 2015, we found care was not always effective and the provider had breached Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Areas required improvement in relation to the management of a person's diabetes and failure to consistently seek appropriate health care guidance. At this inspection we found concerns remained related to both these same issues and as such the breach is continuing.

At our last inspection we found the provider had not consistently sought guidance from the appropriate health care professionals in regard to turning routines. A turning routine is a medical intervention commonly associated with managing a person's care once they have been assessed at risk of skin pressure damage. At this inspection we again found a person whose skin risk assessment had identified them at risk of skin pressure damage and had been placed on a turning routine. This person was not under the care of a district nurse for this identified medical risk therefore it was not clear how this decision had been reached. The acting manager was unable to identify how long this person would be on a turning routine and whether the routine was helping to protect their skin condition.

At our last inspection we found shortfalls within the guidance available for staff to support a person living with diabetes. At this inspection we found care staff were carefully following guidance they had been provided for one person however it was unclear where this guidance had come from. The person had previously been living in their own home and was supported with their diabetes management by a homecare agency. The care staff were following the home care agency's guidance which had been provided by the person's family when they came to live at the service. However there was no evidence to show if this had been approved by an appropriate health care professional. The acting manager confirmed they had not contacted this person's GP since they had been living at the service to assure themselves this guidance was accurate and up-to-date. The acting manager requested a senior member of staff contact this person's GP and family to seek clarification.

The above are a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff spoke positively about the support they received from senior staff, some recently recruited staff had been not been appropriately supported through their induction. Records identified these staff had been recruited whilst the previous registered manager had been in post. We spoke to one of the staff concerned who confirmed they had undertaken shadow shifts and undertaken training during their induction but acknowledged the induction was not well structured. There were no records to determine what these staff had covered during their induction period and whether they had been 'signed off' by a senior staff member as competent prior to working independently. These staff had not had a probationary period review or supervision since they had been in post. This meant there was a risk these staff may not be working in line with the provider's policies and procedures. The acting manager acknowledged these staff had not been adequately supported in line with the provider's new starter procedures and committed to arrange for these staff members to complete a retrospective induction.

A training programme was in place which demonstrated staff received regular training and updates, this included moving and handling, food hygiene, first aid and mental capacity. Staff told us they found the training they undertook helpful for their roles. During our inspection we saw staff using correct methods and techniques to support people such as with infection control and moving and handling. Training was undertaken either by classroom type sessions or via an online method. One staff member told us, "I have to say the training is pretty good." Another said, "Training has been useful, gives me confidence I am doing things the right way." The acting manager had upcoming training booked in areas such as dementia and accident and incident reporting.

Care staff had received training and demonstrated an understanding of the principles of the Mental Capacity Act (MCA) and gave examples of how they would follow these in people's daily care routines. However there was limited evidence of mental capacity assessments within people's care plans, those that were evident did not have clear decision specific best interests explored.
The Care Quality Commission (CQC) is required by law to monitor how providers operate in accordance with the Mental Capacity Act 2005 (MCA). The MCA requires assessment of capacity must be decision specific and must also record how the decision was reached. People's care documentation provided some clarification and guidance for staff on people's ability to make decisions on their daily living routines. However there was limited evidence as to how people's capacity had being assessed using the MCA principles. This is an area that requires improvement.

Staff were able to explain the implications of Deprivation of Liberty Safeguards (DoLS) for people they were supporting. DoLS forms part of the MCA. The purpose of DoLS is to ensure that someone, in this case living in a care home, is only deprived of their liberty in a safe and appropriate way. We saw the DoLS applications to the authorising body had been made when appropriate and where an authorisation had been granted the conditions were seen to be adhered.

The home's dining room was on the lower ground floor where the majority of people chose to eat their lunch on both days of our inspection. People were very positive about both the standard of food and the choices available to them. Meal times were relaxed; staff were efficient and friendly and were responsive to people's likes and dislikes and quantities eaten. One person said, "My food is important part of my day, I enjoy coming down for my meals." Music was played in the background, people chatted together and the atmosphere was very comfortable, people enjoyed the dining experience. We saw one person had requested a larger piece of fish for lunch and this was quickly and efficiently handled. One person said, "The food is great, I have put on weight which I needed." The home's main cook was confident about their responsibilities and knowledgeable about people's dietary requirements. People whose nutritional assessments had placed them at risk of not eating or drinking sufficient amounts were effectively supported by staff to have their support needs met. People who consented were weighed regularly and this was monitored by senior staff. One staff member said, "Supporting residents to get enough calories and fluids in to them can make a big difference to their quality of lives."

Staff handover between shifts was thorough and staff had time to discuss matters relating to the previous days and shift. Staff were able to raise points and their input was valued and listened to. Staff demonstrated they had a clear understanding of people's habits and routines whilst discussing aspects of people's care, health and support needs.

Good

Is the service caring?

Our findings

We saw people were treated with kindness in their day-to-day care. People told us they were satisfied with the care and support they received. One person said, "We are lucky, nice staff here." Another told us, "I'm very happy here, pleased with my choice."

Due to the large building and its layout over different floors staff used walkie talkies to communicate with each other. Although this was seen as an effective way for staff to relay messages some staff were not consistently sensitive to its use. For example we overheard a staff member on one occasion refer to people by their room numbers whilst communicating via the walkie takie. We spoke to acting manager who assured us this would be addressed and was not usual protocol.

The atmosphere within the communal areas of the home was relaxed and calm. People were seen moving freely around and enjoying the communal living spaces. The service's garden terrace which overlooks the sea was a popular area. People were seen relaxing and reading and chatting with each other whilst enjoying beverages. One person said, "As soon as I saw the view I was sold, lovely space to sit and relax."

We saw many kind and genuine interactions between staff and people. For example staff discreetly asked people if they required the toilet. We saw occasions where staff took time to explain to people and orientate them to the home's routines. One person had fallen asleep and as they woke a staff member took time to orientate them to the time of day and asked if they were 'getting hungry for lunch.' Staff knocked on people's doors before entering. Staff strove to provide care and support in a happy and friendly environment. A member of kitchen staff was singing and a person was joining in and tapping along with their hand. We heard staff patiently explaining options to people and taking time to answer their questions. We also heard laughter and good natured exchanges between staff and people during our inspection. One person said, "A sense of humour is so important when we all live together." One person appeared unsettled during a meal time as they had the sun shining in their eyes, staff were quick to notice and check if they could pull a blind down to make them more comfortable.

We looked at all areas of the home, including people's bedrooms. Rooms held items of furniture and possessions that the person had before they entered the home and there were personal mementoes and photographs on display. We spoke to people who preferred to stay in their room. One person told us, "I am happy in my room, I have all my things around me, my photos and bits and bobs." If I wanted to go down to sit in the lounge, I could but I don't want to, everyone respects that." Another told us, "We get the choice, but it's always our own decision, great respect is shown to us in lots of ways."

People's care plans contained personal information, which recorded details about them and their life. One person said, "I know I have got a care file, I know roughly what is in it but I'm not too bothered about the detail, but I know I could if I wanted to." Care records were stored securely. Confidential information was kept secure and there were policies and procedures to protect people's confidentiality.

We saw visitors were welcomed during our visit. Relatives told us they could visit at any time and were

always made welcome. A visitor said, "I visit regularly and stay as long as I want, I am always offered a drink and feel welcome." One person said, "I've had some of my great grandchildren come and visit and they love it here."

Requires Improvement

Is the service responsive?

Our findings

Most people told us they felt staff knew them well and were listened to and received the support they needed. However we found the service was not always responsive to people needs or respected their wishes.

A person had identified in their care plan that they did not wish anyone including family 'to be contacted if they were dying'. However within their care documentation we found a recent letter which had been sent from the service to a member of the person's family member informing them that this person was now on 'end of life' care. The acting manager told us this person had capacity and this should not have happened.

The acting manager informed us that when they started work at the service they had identified that some people's care plans required 'significant updating.' We found multiple examples where care plans were not providing clear guidance for staff on how to respond and support people. For example a person who was staying at the service on respite had very limited information available for staff on how to meet their needs. Some of the information that was included was not accurate. For example their care plan identified they required 'full assistance with dressing' however their daily care notes repeatedly stated they had arrived dressed for breakfast independently. These care notes also identified there had been occasions where they had got up and dressed in the early hours of the morning and appeared distressed, however there was no reference or guidance for staff on how to manage these behavioural patterns. This person was seen to be unsteady whilst moving around the service and at one point called out to a passing inspector to support them to stand. The only information available within their mobility care plan was, 'X walks with a stick.' We spoke to the acting manager regarding this person and they acknowledged the care plan did not provide clear guidance for staff on how to support this person. At a later point in the inspection staff supporting this person whilst they were moving around the home and their care plan had been updated.

On the first day of the inspection a trip was planned visit to a nearby coastal town. People told us they were looking forward to the day trip. One person said, "Oh yes, I'm looking forward to my posh fish and chips," Another said, "It's been a while since I've been out on a coach trip so I am looking forward to today." The trip had been organised by the home's activity coordinator and was a popular event. However for those people who remained at the service there were periods of the day where people were left for extended periods without meaningful interaction in the lounge. We also noted people who remained in their rooms received minimal one to one time apart from personal care and mealtimes. The activities co-ordinator kept a log of who they had interactions with and who had joined in with planned activities however this document was not available to the inspector during the inspection process. The acting manager acknowledged that people who either chose or were unable to leave their rooms were having limited interaction with the activities coordinator. The acting manager said, "People who stay in their rooms are having the activities coordinator visit them approximately every seven days."

The above issues related to reflecting people's preferences and meeting their needs are a continuing breach of Regulation 9 HSCA (RA) Regulations 2014.

However for other people who left their rooms we also received positive feedback regarding the social engagement that was on offer. A range of external activity providers routinely visited the home; such as motivation and animal therapy. One person told us, "I'll dip in and out of the bits I want to but there is usually something going on." We found some care plans provided clear detail on people's behaviours and triggers and how staff could best manage these. One staff member said, "The eye has been taken off the ball with some of the care plans but I usually find them helpful and a good point of reference."

The provider had a clear complaints policy which was available and accessible to people, however we found an example where a person had not be supported in line with the providers policy. One person told an inspector they had recently been troubled by a conversation they had whilst being supported by an external health care professional. The person had verbally reported this incident to a senior care staff member at the time. Although the staff member could recall the incident they had not recorded or taken any action as a result of receiving these concerns. The inspector shared this information with the acting manager who responded by immediately beginning an investigation in line with the providers policies. This is an area that requires improvement.

People told us they attended resident meetings where they discussed a range of topics. One person said, "The main thrust is usually food." Meeting minutes identified issues that had been raised were seen to have had action taken as a result. For example a fruit bowl was now left out and refilled by kitchen staff. There had been several issues with laundry which people told us had improved as a result of discussing it in a meeting. The provider commissioned a range of surveys to check on satisfaction levels. These included people and their relatives and other stakeholders such as health care professionals who visited the service. The most recent survey was undertaken in December 2015. The feedback was seen to be mainly positive however the acting manager acknowledged that they had not as yet created any action points from the feedback. However they had begun to explore the themes and highlighted areas they wanted to seek further clarification.

Requires Improvement

Is the service well-led?

Our findings

All care staff we spoke to acknowledged the home had been through an 'unsettled period.' At our last inspection in April 2015 the registered manager who had been in post for many years was due to retire. Their replacement began in July 2015 and left their role in April 2016. Staff told us this period had been difficult. At this inspection there was an acting manager in post who had submitted an application to the CQC to become the registered manager. The acting manager told us they had been provided with only a brief handover from the previous registered manager. They told us the limited effectiveness of this handover was compounded by the deputy manager and area manager also leaving their posts around the time they began. The acting manager, although now more established in their role, told us they felt they had initially not been supported in their role and did not have clear oversight of the issues which required attention at the service when they began.

The home was having monthly quality assurances visits from a regional manager. They produced a report which in part was populated by the acting manager with statistics such as the number of hospital admissions and accidents since their previous visit. The regional manager quality assured a sample of people's care plans and made both broad and specific recommendations for the acting manager. Recent reports identified that shortfalls in the service had become apparent. The report dated June 2016 stated, 'The manager has inherited a significant number of issues' and, 'There is a lot of work to be done.' The shortfalls we found at this inspection had only in part been identified by the quality assurance process. For example the audit of accidents and incidents provided the acting manager with limited oversight. They were recording the number of accidents each month but no further analysis of specific patterns and trends; for example to identify if it was the same people who were regularly having falls. The acting manager acknowledged there were aspects to the running of the service and the wider provider head office function they were still learning about. For example the acting manager was unable to clarify if the service's call bell systems was auditable. This meant they had not been assessing response times on call bells to assure themselves these were answered in a timely manner.

We saw the acting manager had audited people's care plans; however they had delegated, in part, this task to other senior staff who had not identified the shortfalls we had found with care documentation. The acting manager acknowledged these care plan audits had not been effective. They said, "This is my error in judgment." Although staff were able to talk through people's care and support needs with confidence we found people's care plans did not consistently provide an up-to-date guide for staff. Accurate and up-to-date care plans are important for staff particularly when the service is utilising agency care staff to manage current staff vacancies. We found daily care notes did not consistently provider accurate reflection of what people had done during a timeframe, for example one person who had been out on a day trip indicated they had spent the day in a lounge watching television.

The shortfalls identified in leadership and their oversight, quality assurance and records are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff meetings were held regularly and minutes of these identified staff discussed aspects of people's care

and support. Staff told us these were an opportunity to explore issues relating to people as well as general working practices and training requirements. We saw minutes from the most recent meetings which verified this. One senior staff member said, "There are different meetings for seniors and as well as bigger ones when we all get together."

People and staff spoke positively of the home's new acting manager. One person said, "I have seen quite a bit of them seen they have been here." A staff member said, "It feels like we are back on the right road now, the last year has been bumpy." All staff told us they felt the service was running better now the acting manager was in post. One staff member said, "Things have definitely improved, communications better, the manager has worked hard and it's a better place to work." We found the provider and other senior staff were responsive to our comments and feedback throughout the inspection and took immediate corrective action in multiple areas during the inspection. The acting manager said, "I know I have got my work cut out for me but I am determined and confident I can get things working well again."

The acting manager said they now felt well supported by the provider. They had begun to attend regular provider management meetings to discuss areas of improvement. They said they felt well supported by the providers 'head office' function. The provider had offsite services which supported with human resource management, administration support and payroll services. On the second day of our inspection the acting manager was being supported by an experienced registered manager from another service. The acting manager said, "I feel the cogs are now starting to fit together and I know who to contact for support and guidance."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's treatment and care must be appropriate to the individual. The registered provider had failed to ensure peoples care was reflecting their preferences. 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured people's safety and welfare had been protected by adequately assessing risk and mitigating the risk. 12(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure all areas of the premises were secure. 15 (1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have an effective system to regularly assess and monitor the quality of service that people received. 17(2)(a)

The registered provider had not ensured people's care records were complete and accurate. 17(2)(c)