Vicarage Nursing Home Limited

The Vicarage Nursing Home

Inspection report

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26 February 2016

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 24, 25 and 26 February 2016 and was unannounced.

The home was last inspected on 20 October 2015 where we gave it an overall rating of requires improvement. We had identified the provider was in breach of Regulations 12, 17 and 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to staff not always supporting people to move safely, a lack of effective quality assurance procedures and failure to display their ratings from our previous inspection. We asked the provider to make improvements and send us their action plan by 17 February 2016. We did not receive this action plan prior to this inspection. We found that little improvement had been made since our last inspection.

The Vicarage Nursing Home is a specialist dementia nursing home. It is registered to provide accommodation with nursing and personal care to a maximum of 52 people. There were 37 people living at the home on the day of our inspection.

There was no registered manager in post. The service is required to have a registered manager in post. The home had a manager who was present during our inspection. 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.

People were not always cared for by sufficient numbers of staff. Agency staff were used to cover the shortfalls in staffing but they did not always know what people's needs were. This was because they were not always provided with or had access to this information. Relatives had concerns because this meant there was not always a consistency in people's care and support.

People were placed at risk of harm because staff did not always know the risks that were associated with their care and support. Agency staff were not always provided with information that would help them keep people and others safe within the home. Medicines were not always managed safely.

People who were cared for in their bedrooms did not have call bells placed within their reach and had to shout for assistance. Because staff were busy in other areas of the home people's shouts for assistance were not always heard by staff. This placed people at risk of harm because staff could not always meet their needs in a timely manner.

The provider offered specialist dementia care but staff were not clear on how they were to meet people's dementia care needs. Staff were not supported by the provider to carry out their roles effectively. Staff did not have one to one support that would have enabled them to raise concerns and identify training they needed to meet people's needs.

People and relatives liked the staff who cared for them; however they felt the inconsistency of agency staff made it difficult for staff to understand their care needs.

Staff knew what specialised diets people needed, although the information relating to people's eating and drinking was not always kept up to date. Staff did not always keep accurate records to show what people ate and drank each day when this was needed. This placed people at an increased risk to their health and wellbeing.

Staff were not able to always ensure people's dignity because they were sometimes too busy to support people when they needed it. Staff knew the care they provided was task focused and not always individual to each person but felt too rushed to be able to give people the time they needed.

There was little accountability within the home and staff were not clear on their own and other staff's responsibilities. No processes were used to assess and monitor the quality of care provided and no one took responsibility for ensuring tasks were completed by staff. Staff and managers who were aware of shortfalls within the home had taken little action to address these.

Where people were asked for their permission this was respected. However, not all staff asked people's permission before they supported them. Some people needed support to give consent and make decisions about their care and treatment and staff worked with other professionals to make sure these were in people's best interests.

People and their families were able to give their feedback and opinions on the service provided. They were given opportunities to raise concerns and felt these were dealt with quickly.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the

report.

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.
People were placed at risk of harm because there were not enough staff to safely meet their needs. Staff were not always aware of risks associated with people's care and behaviour. Medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.
People were cared for by staff who were not supported and supervised in their roles. Staff respected people's right to make their own decisions and supported them to do so. People were given support to eat and drink, although information relating to people's eating and drinking was not always kept up to date.

Is the service caring?

Requires Improvement

The service was not always caring.
People's dignity and privacy was not always respected by staff. People were not always responded to when they wanted to talk with staff. People felt they were looked after well and positive experiences of staff's caring natures were shared with us.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People were not always provided with care and support that was individual and personal to them. People and their families were provided with opportunities to give their opinions and raise complaints and concerns.

Is the service well-led?

Inadequate

The service was not well-led.
The home did not have a registered manger in post. Staff and managers were not clear on their responsibilities and there were no clear lines of accountability. Systems were not in place to assess and monitor the quality of the service provided and action was not taken when shortfalls in the service were known.

The Vicarage Nursing Home

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 carried out this inspection in response to concerns we had received and information that was shared with us from the local authority. Because the areas of concern were widespread we completed a comprehensive inspection and looked at all five key questions. We had received concerns that people's safety was at risk because there were not enough staff to support them. Concern was raised that because a high number of agency staff were used there was no consistency of care for people. This was because agency staff did not understand people's care needs. We also received concerns that there was a lack of effective leadership and management at the home.

This inspection took place on 24, 25 and 26 February 2016 and was unannounced.

The inspection team consisted of four inspectors.

We carried out this inspection in response to concerns we had received and information that was shared with us from the local authority commissioning development and procurement team and adult safeguarding team. Because the areas of concern were widespread we completed a comprehensive inspection and looked at all five key questions.

During the inspection we spoke with seven people who lived at the home and three relatives. We spoke with 14 staff which included activities staff, care staff, nursing staff and agency staff. We spoke with the manager, the business support manager and a managing director. We also spoke with one visiting professional from the Home Treatment Team. We viewed eight records which related to consent, people's medicines, assessment of risk and people's needs. We also viewed other records which related to staff training and recruitment and the management of the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us. We observed people's care and support in the communal areas of the home and how staff interacted with people.

Inadequate

Is the service safe?

Our findings

At our last inspection we found staff did not always use safe moving and handling techniques. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan outlining how they would make these improvements. This was not provided prior to our inspection and we found no improvement had been made.

People were still supported by staff who used moving and handling practices which could put people and themselves at risk of injury. We saw two people left in stationary wheelchairs where the footplates had not been put in place. One person's feet did not touch the floor whilst the other person just had their toes touching the floor. This meant their legs were not supported which could cause circulatory problems and damage to skin. We also saw two occasions when staff pushed an armchair and a dining chair with people sat in them. We saw that equipment was available for staff to use to move and position people safely but on these occasions they had not used it. Staff told us they had received training in how to move people safely but we did not see this training put into practice by all staff. The business support manager confirmed that moving and handling training had been updated for staff since our last inspection.

The provider had not ensured one person had sufficient quantities of medicine to meet their needs. We found this person did not have any medicine in stock and as a result had not received their medicine for the five days prior to our inspection. These medicines were prescribed for specific medical conditions this person had. This had not been picked up by staff prior to our inspection. We drew this to the attention of a nurse and the manager. There was a delay in staff obtaining a new stock of medicine for this person and also in seeking medical advice from the person's doctor. We also found this information had not been shared with all staff and no record had been made in this person's daily notes about this person not receiving their medicines or of actions that had been taken. Staff should be made aware in instances such as this so they can monitor the person for any changes in their health and wellbeing as a result of not receiving their medicine. It is important to seek medical advice in this instance because the person may be placed at risk of harm by not receiving medicines that were prescribed to them.

Some people were prescribed a medicine to help with their anxiety and agitation. This was prescribed to be taken only when it was needed. However, there was no information provided to staff to inform them how they could recognise when one person may require this medicine to be given to them. We spoke with one agency staff who told us they had been given no information on managing this person's anxiety or behaviour if they became unsettled. This meant this person may not receive their medicine when they needed it because staff may not recognise the signs of their anxiety.

People were not supported safely at all times because the provider had not ensured staff had the necessary skills and competence. We saw some staff had difficulty supporting people when they became increasingly anxious and unsettled. One person became unsettled and started hitting out at staff who came to support them. One staff member was not able to calm this person and laughed this off saying, "[Person's name] just punched me", whilst they walked away from them. We also observed another person who became

increasingly unsettled and loud which disturbed other people. Staff told us they had not received any guidance on how to support some people with their increased anxiety. One care staff told us, "Sometimes I feel scared and uncomfortable around some of the residents". One agency staff told us they were not given information about why some people may become anxious and the effect this could have on their personalities and the way they behaved. The managing director told us that they expected the homes own staff to support agency staff and give them the information they needed. Staff told us they were often too busy to give agency staff all the information they needed.

People were not always supported by staff who were aware of the risks associated with their care. Some people had one to one supervision and we saw agency staff were often used to provide this. Agency staff did not always know how some people's behaviour and anxiety could be a risk to themselves or other people at the home. This was important because some people had a history of behaviour that had become more challenging recently. One agency staff was unable to tell us about one person's care needs despite telling us they were given a handover when they started their shift. The handover had not included information on how specific risks were managed such as people with increased anxiety. The manager told us that agency staff did not get an induction to the home or the provider's policies and procedures. This was confirmed by agency staff we spoke with. One agency staff told us they did not know what any emergency procedures were as they had not been given this information. They told us they had taken it upon themselves to find this information out. It is important that all staff regardless of status are fully informed of risks associated with people's care, how these are to be managed and emergency procedures in order to keep people safe at all times.

People had been involved in incidents that had or could have affected their health, safety and welfare. We found these had not always been investigated by the provider. When incidents were reported by staff there was no follow up recorded or evidence to show what actions had been taken to prevent further occurrences. Staff told us about recent incidents which had occurred at the home and that some people's behaviour had become more challenging in recent months. They told us there was a lack of information on how to manage risks associated with people's care and especially how to manage their behaviour. One staff member said, "We have had no guidance or direction about how to manage these people's behaviours. As staff we just muddle through". One staff member told us they did not always report incidents and was not sure if other staff reported incidents. The manager told us that they did not review incident forms. They confirmed that they or the provider did not complete any "formal analysis" or monitor trends. It is important to report and monitor all incidents that occur in order to be able to recognise and respond to any trends, especially in people's behaviour. We were therefore not assured the provider had taken all steps to mitigate risks to people and others within the home.

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

People's needs were not always safely met by sufficient numbers of staff who were suitably skilled and experienced. We saw four people who were cared for in their beds did not have a call bell within their reach which meant their only way to ask for help was to shout. We heard people asking and shouting for help from their bedrooms. The tone of one person's voice indicated they were in distress yet no staff were around to help them. One person told us they were uncomfortable, another person was sat in wet nightclothes in their armchair. On each of these occasions inspectors had to find staff to support these individual people. Staff told us there were never enough staff on the floor and if people needed support from two staff it often left no staff on the floor. One care staff said, "It's shocking sometimes, there are not enough staff for the size of the home and the needs of the residents". One staff member told us that due to people's dementia they did not understand what the call bells were for and so they kept using them. The staff member told us that because

of this they carried out regular checks of people who were nursed in their rooms rather than giving them the call bells. However, daily records did not show that people were checked on a regular basis and we found several occasions when no staff were available on the floor because they were supporting other people. We were therefore not assured that people received support from staff when they needed it.

We saw there was not sufficient staff available to support people in the communal areas of the home at all times. One relative told us there had been staff shortages and a lot of agency staff being used. One care staff said, "Staffing levels are terrible. It can vary and can only be four to five staff on rota some days". We were informed by the manager that there should always be two staff members in the conservatory which was where many people spent their time. We observed that this was not always the case because following breakfast one day we saw no staff were present in the conservatory. Staff told us this was not always possible because there were not enough staff. They told us that they would 'keep an eye on people' from the dining room and lounge areas if they were supporting people in these areas. Staff told us they knew this was not ideal because some people were at risk of falls and had poor mobility. On several occasions we saw staff had to rush over to people who were trying to stand unaided or were walking without their mobility aids. On these occasions staff were in the dining room or lounge or were busy supporting other people and could not see what was happening in the conservatory.
Relatives and staff told us that because different agency staff were used this had an impact on the continuity and consistency of care that people received. One relative said, "There are too many agency staff who don't know [person's name]". One staff member said, "Agency staff are used a lot but they don't know people's needs. It's not always the same agency staff so there is no consistency for people".

The provider had not kept under review the staffing levels and skills mix to be able to respond to the changing needs of people who used the service. The manager said, "Can we meet people's needs, my feeling is we can't with the staffing levels we have". The manager, business support manager and the managing director told us a review of staff numbers had only been done after incidents had occurred within the home which had an impact on other people and staff's safety. It was these incidents which had led to our inspection. Following this review staffing had been increased by two and the manager and business support manager told us these had been filled by agency staff as there were not enough of the home's own staff to cover this.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relative's told us they thought their family members were looked after safely. Staff had been trained to recognise what signs could indicate people were at risk of or being placed at risk of harm or abuse. They were able to tell us what action they would take and who they could report their concerns to. Some staff told us they were concerned people were not always safe at the home because they were short staffed. However, despite their concerns staff had not taken the action they told us they would if they thought people were at risk of harm.

The provider had recruitment processes in place which were used to keep people safe. Two staff confirmed they had not started work before employment checks had been completed on them. The business support manager spoke about potential new staff who were waiting to start work at the home. They showed us the identity, employment and background checks being completed. They told us these staff would not be offered a start date until all these were checks were satisfactory. This helped to ensure potential new staff were suitable to work with people living at the home.

Requires Improvement

Is the service effective?

Our findings

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 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. We saw best interests decisions had been made on people's behalf when they did not have the capacity to make specific decisions. Other relevant people had been involved in helping to make these decisions. Some people had relatives who acted as their power of attorney and we saw they were involved when decisions about a person's care needed to be made. Staff understood that any decision they made on behalf of people had to be made in their best interests.

People's permission was not always sought by staff before they supported them. One staff member moved a person who was sat in a wheelchair. The staff member did not ask the person if they wanted to be moved before they started to move them. The person said twice they did not want to be moved and it was only when the person raised their voice that the staff member stopped moving them. Other staff we observed took care to ask people's consent before they supported them. One staff said, "We always ask their permission before providing care. We tell them what's happening". Another staff member told us, "We need to provide them with choices with everything that we do and make sure they understand what is happening".

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found applications were submitted to ensure that people were not being unlawfully deprived of their liberty. The applications had been made to the supervisory body and we had been notified as required when these applications were authorised. Not all staff we spoke with knew who had a DoL authorised or the reason for these. Staff must be aware of the reasons why any person is subject to a DoL. This is because, for example, a person may not be safe to leave the home alone due to being at risk on the roads. If staff were not aware of this DoL they may let the person walk out of the door and place them at risk of harm.

Some people were looked after in their bedrooms due to their care needs and were reliant on staff for their care and support. We saw two people cared for in their beds who did not have drinks within their reach. One person was awake and lying in their bed. Their drink was on the other side of the room where they could not reach. This person told us they were thirsty. Staff told us they tried to ensure people had enough to eat and drink throughout the day but told us they had no direction given to them on how much fluid people should have each day. They told us it was the nursing staff's responsibility to monitor what people drank. Risks associated with people being able to eat and drink were assessed and specialist advice was sought. However, we did see one person had out of date nutritional information in their room which stated the person was on a normal diet. One nursing staff told us this was out of date and this person was in fact on a soft diet. Care staff we spoke with were able to identify that this person needed a soft diet. However, there was a risk that new or agency staff may use the information displayed in this person's bedroom. This could

place the person at risk of harm through choking.

People were supported by staff to eat and drink in their rooms and in the dining area. When one person did not want what was on the lunch menu we heard them say, "That's lovely, that's great", after staff offered them an alternative. Choices of meals were offered to people and support was given when needed. In between meals people in all areas of the home were offered drinks and snacks.

The provider offers specialist dementia care and at our last inspection we had raised concern because staff were confused about what approach to dementia care they should use. The provider advertises on their website that they use a nationally recognised approach to dementia care which is called the Butterfly Approach. At this inspection we found that staff were still not clear on what approach they should use. One staff member told us they used it with some people but not others. Another staff member said, "We're trying the butterfly approach but I'm not sure". The managing director told us they were not using this approach due to cost and they didn't feel it would work with people who lived at the home because it was, "quite narrow and not suited to people with advanced dementia". We therefore did not have the assurance that people's needs were met by staff who understood how to meet their dementia needs.

Staff did not always receive the support and supervision they needed to carry out their roles effectively. Staff told us they did not receive regular one to one support. This is called supervision. One staff said, "I can't tell you when my last supervision was". Another staff told us they had only received one supervision in the last two years and thought this was due to a lack of staff. However, they told us, "I do feel I have daily support to do my job". They told us this support was from their colleagues rather than from managers. Staff considered the training they received helped them to meet people's needs. Some staff had not received any training in how to support people with more complex needs which could be associated with their dementia. These staff told us they did not always feel confident in their roles. The business support manager showed us dates they had booked for training for new staff who were due to start work at the home and for other staff that needed it.

When people were taken ill staff recognised when to contact an ambulance or when to contact their doctor. Staff told us the doctor from the local surgery came to the home each week and would see any person the staff had identified as needing to be seen. These appointments were individually arranged so the doctor could spend the correct amount of time with each person. People were referred to other healthcare services as required such as the district nurse team or speech and language therapist.

Requires Improvement

Is the service caring?

Our findings

People's dignity and privacy was not always respected. One relative told us they found their family member had faeces under their finger nails. They also told us, "We have to ask for [person's name] face to be cleaned after meals and staff can take time to come back to you". One person had fallen asleep after their breakfast. They were sat alone at the dining room table and were asleep and wearing an apron which had food down it. Staff did not offer support to this person to maintain their dignity and help clean themselves.

People were supported by staff who understood the importance of respecting people's dignity and privacy but we saw this was not always put into practice. They told us one way they respected people's privacy and dignity was to close doors if people were in their bedrooms. However, on the first floor of the home we saw some people were cared for in their bedrooms. We were able to see four people in their bedrooms because their doors had been left open. One person was sat in their armchair and was naked from the waist down. On another occasion this person had been incontinent of urine and was visibly wet. They were asking for help but staff were not around to help this person maintain their dignity or privacy. Another person was in bed still in their nightclothes yet their door had been left open. We observed one staff member letting themselves into a person's bedroom without first knocking on their door and asking if they could come in. Staff told us there were not enough staff to ensure everyone received the support they needed and as a result their dignity was being compromised. We were not assured that the provider, manager and staff had taken all steps necessary to ensure people's dignity and privacy was respected at all times.

People were living with dementia and some had difficulty communicating and expressing themselves verbally. We saw situations where people tried to engage staff in conversation but this was ignored. We heard one person asking to get out of their wheelchair and did not receive a response from staff. We saw one person continually shouting for 'help' and was ignored three times by the same care staff as they walked past. We saw one person tried to start a conversation about a family member with a staff member that was sat next to them. The staff member gave an abrupt response to the person, folded their arms and looked away. We saw different staff members supporting people on a one to one basis. There was often little interaction with the person and staff tended to just follow the person around the home. At times the communal area of the ground floor conservatory became very busy. We saw one person become increasingly anxious and unsettled. Staff did not support or interact with them as they were busy supporting other people. Another person was observed to sleep for the majority of the day and staff only interacted with them at meal times and to take them to the toilet. A film and television programmes were played via a projector onto a wall in the home's conservatory. However, two people had their chairs positioned against this wall so were unable to watch. These two people spent most of their day asleep in their arm chairs. Staff told us they were so busy they felt they could only provide basic care for most of the time. They were not able to spend any time with people other than the time needed to complete the task they were required to perform. The manager said, "The care staff are very task orientated because they don't have the time, it's do, do, do and they have to focus on the task". We found staff did not always engage with people in a way which had a positive impact on them or showed they respected them.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People and their relatives felt involved in their own care and felt they were looked after well by staff. One person said, "They are looking after us well. The only thing is there is no one to talk to but I can't say anything bad about the staff or the cook". One relative told us, "They do care for [person's name]". They told us they felt involved in the care of their family member and was involved in a recent medicine review to discuss any changes in medicines that were required. Staff told us they always tried to involve people in making their own choices and we did see some good interactions throughout our inspection. We saw some staff offering choices of food and drink, asking people if they were comfortable and settled before leaving them. One person did not want to go to the dining room for their tea so the care staff gave them the option to eat where they were. The staff member made sure the person was comfortable and had everything they needed. Staff reassured and explained what was happening when they moved people with the use of a hoist and we saw staff communicated between themselves to provide updates on what was happening within the home. Some staff who worked at the home told us they had worked there for many years. They told us this had helped them to build relationships with people and their relatives.

We spoke with one visitor who told us they were grateful for the privacy they and other visitors had been given with one particular person. This person was receiving end of life care and their visitors told us they had been impressed by the quality of care provided by staff. They told us that staff had spent time in getting to know this person and their visitors. They told us the staff had been very accommodating and this person had been given privacy and respect to maintain their own religion.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and support that was individual and personal to them. One relative said, "The care is variable. We don't get good communication when there is a change in [person's name] condition". Some staff we spoke with were able to tell us in depth about people's needs and their preferences. They told us how they should ensure people received care that was centred around the individual person. However, even though they were aware of what they needed to do they told us this was not always possible. One staff said, ""There is no time to spend with residents, we're just doing the basics". Care staff, nurses and managers all told us that care was 'task led' for most of the time. The manager told us some people were in the later stages of dementia and had increased needs. They told us this meant that staff needed to give people more time to be supported with their needs. This was not happening because staff could not give people the time they needed.
People were not always supported to take part in social activities. The provider employed three staff who were responsible for overseeing 'activities' within the home and supported people to engage in their hobbies and interests. Throughout our inspection we saw occasions when these staff were utilised on the first floor of the home helping the care staff to support people in their bedrooms. However, we did see some people engaged in interests such as listening to music and being supported to make craft items. One afternoon was filled by an entertainer who came to the home to sing. One staff member said, "They [activities staff] do a great job". Although these staff were employed to support people with their hobbies and interests we found they were often unable to perform this role because they supported care staff. This meant that people did not always receive the support they needed to maintain their hobbies and interests.

One staff member told us that people had 'rummage boxes' in their rooms which contained items that were important to them and were used with people to reminisce. When we asked why these were not with people in the conservatory staff told us the activities staff were usually around to facilitate this but they had to help upstairs as they were short staffed. If staff are unable to respond to people who are anxious there is a risk they will become more unsettled and their behaviour could have an impact on themselves and others around them.

Changes in people's care were not always responded to and care records were not always kept up to date by staff. Information given to staff by outside professionals was not always used to respond to changes in people's needs or update care records in a timely manner. The manager and staff had not been aware one person's doctor had recommended the removal of their catheter eight days prior to our inspection. We found that although this information was recorded no one had acted on this. One staff member told us one person had recently been re assessed by the mental health team. It had been agreed for this person to be placed on continuous supervision with a staff member. They told us this information had been passed verbally between staff and we saw the one to one supervision was in place. However, there was no record in this persons care plan to say how this was to be achieved. We also saw this person's care plan was not updated until two days after this re assessment. This was important as this person had been re assessed and placed on continuous supervision due to becoming physically aggressive and their care plan did not reflect this change in their care needs. The manager told us they were aware that people's changes in needs and behaviour were not always recorded.

One relative told us that any concerns they had were dealt with quickly. Meetings were held at the home every two months where people and families met with the activity co-ordinator who acted as a family liaison. People and their families had opportunities to discuss concerns and make suggestions for improvements at these meetings. The activity co-ordinator told us that no management were present at these meetings. This was at the request of families who felt more comfortable discussing concerns without managers present. Staff told us they supported people and relatives to raise complaints or concerns if they wanted. They told us that complaints were resolved quickly and efficiently but they were not sure if these were recorded. We saw records of complaints raised which showed they were responded to and resolved in line with the provider's complaints procedures.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that risks associated with staff practice had not been addressed. We also found that accurate records were not maintained in relation to people's care and treatment and although systems were in place for audits these were not always followed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan outlining how they would make these improvements. We asked the provider to send us their action plan by 17 February 2016. We did not receive this action plan prior to this inspection.

It is a condition of the provider's registration that there is a registered manager in post. There was no registered manager in post at the home. The previous registered manager had submitted their application to de register with us. The current manager commenced employment in October 2015 and we have not received an application for them to register with us as a registered manager. We found there was some confusion over the registration process the manager needed to follow because both the manager and managing director thought they were registered with us as a registered manager. We found the provider had not informed us of the nominated individual not being available. This had resulted in the provider not receiving our last inspection report before it was published and not receiving our request for an action plan to be submitted. We also found that we had no registered person to communicate with when we had concerns to raise about the home. One staff member had responsibility for submitting statutory notifications to us and we found they were not supported by the provider to enable them to do this in line with regulatory requirements. It is the provider's responsibility to keep us informed of any changes in the management of the home and to provide us with up to date contact details of the registered persons.

After our last inspection we had asked the provider to share the inspection report summary with people, relatives and staff. Staff told us they had only seen the ratings poster but had not been given any detail about the inspection. Staff told us that relatives had been asking about the last inspection report and they had been referring them to our website to view the report. Two staff confirmed that people, relatives and staff had not received the inspection summary.

We found the provider did not have effective quality assurance systems or processes in place to assess, monitor or drive improvement in the quality and safety of services provided. The manager told us there were no quality assurance systems in place and they were aware no quality checks were completed. The manager told us they did not have responsibility for completion of any quality checks despite being the manager of the home. One nursing staff and the business support manager confirmed that the last medicine audit was August 2015. Actions had been identified at this audit which had not been followed up on. The business support manager confirmed that other quality checks including supervision audits and health and safety audits had not been completed since October 2015. The managing director told us they were often present at the home where they considered they had an oversight on the running and culture of the home. They were not aware quality checks were not being done.

We found there was a lack of effective governance and accountability at the home and that staff were not

always clear on their responsibilities. The provider had not taken responsibility to ensure people's needs were met safely. We found that communication between nursing staff was not always effective and involvement from the provider was often lacking. When we arrived at the home the first two care staff we spoke with did not know who was in charge of the home. No staff member had taken responsibility for ensuring a person's catheter was removed. Even when we alerted nursing staff and the manager to this it took two more days for this to be actioned as no one took responsibility for overseeing this. Staff were not clear who had responsibility for checking daily records were completed. People's care records did not always reflect their current needs following changes to their care and treatment. They also did not accurately reflect the care that staff told us they provided. According to one person's record they had not received any personal care on five separate days so far in February 2016. One person's room check chart showed that this person had not been checked for just over four hours despite the chart stating this should be done every 20 minutes. Staff we spoke with told us people did receive their personal care but they often neglected to complete the records because they were busy. One staff said, "It's rush, rush, rush. It's like a conveyer belt". The manager told us they were aware quality checks were not done and care records were not kept up to date but had not taken action to resolve this. The managing director was not aware these records were not up to date or accurate. Throughout our inspection staff, managers and the managing director apologised for areas of concerns we identified. However, we found that no one had taken responsibility for these areas prior to our inspection despite most staff and managers being aware of the shortfalls within the home.

We found personal information was not always kept secure. People's completed daily records were placed in an 'archive room' and we found the door to this room was open. We informed two managers that this door was open but no action was taken to secure this room and the personal information until the last day of our inspection. The nursing station on the first floor contained 'handover sheets' which contained information on people's medical conditions and care and dietary needs. These handover sheets were left lying on top of the desk and were in plain view for anyone who entered the nursing station. There was also a relative's telephone number pinned up on the notice board. We again informed two managers about this the door and the personal information being on view but this door was kept open throughout our inspection. No action was taken to make the personal information contained in the nursing station secure.

Staff gave mixed views on how the home was led and managed. One staff member said, "The manager doesn't help out, they are not a visible presence". Another staff member said, "I don't think the home is well led, you don't see the manager often and they come in late most days". However, other staff told us they felt the manager was approachable and was a visible presence around the home and helped when needed. Staff told us one of the owners had recently come to the home and spoken individually with each staff member about any concerns they had. Staff told us that as a result of this they felt they had the opportunity to contribute to the development of the home and that the owner and managers listened to their concerns. However, one staff told us they did not have confidence in the provider to improve. They said staff concerns were, "falling on deaf ears".

The manager told us, "My concern is that we can't meet people's needs". They told us they had raised their concerns with the provider but little had been done in response. They said, "I'm sinking, I have no support". They informed us that they had handed in their notice and would be leaving 26 February 2016. One staff member told us they had also told the provider how they felt but nothing had changed.

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

At the last inspection we found that the registered persons had not ensured their ratings were displayed at

the home and on their website. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements and to send us an action plan outlining how they would make these improvements. We asked the provider to send us their action plan by 17 February 2016. We did not receive the action plan prior to our inspection.

At this inspection we found the most current ratings were displayed in the reception area of the home. However, on the home's website we found a link which was out of date and did not display the most recent inspection report. We also found no ratings were displayed on the home's website. Providers must ensure that their ratings are displayed conspicuously at the home and on their website.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from relatives was mostly positive but all expressed concerns over the staffing levels at the home. They also were not sure who was in charge of the home on any day. They told us they had the opportunity to share concerns and ideas for improvement through meetings with the activity co-ordinator who also acted as a family liaison. We saw at the last meeting on 21 January 2016 relatives had expressed concern over staffing and had been assured by the activity co-ordinator the home was not short staffed. They were also informed of the management arrangements at the home. The activity co-ordinator told us the managing director would be attending the next meeting in March 2016 to speak with relatives and discuss their concerns.

Staff morale was poor and they told us they were tired because they often worked extra shifts. One staff member told us they were currently doing two staff's work and often left the home feeling, "Like I haven't made a difference". Another staff member told us, "I was proud to work here but now sometimes go home upset. I leave sometimes thinking have I done the best I can today". Staff told us they felt inspired to continually improve and provide the best care they could. They told us it was the people they supported and other staff that inspired them and not the management. We saw that care staff supported each other and throughout the day kept each other updated on what was happening around the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people had their dignity respected at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that staff provided care in a safe way. The provider had not ensured the safe management of all medicines. The provider had not ensured all staff had the skills and competence to meet people's needs safely. The provider had not ensured all staff were aware of the risks associated with people's care. The provider had not ensured that when incidents occurred these were always investigated and action taken to prevent further occurrences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there was effective governance and quality systems in

Treatment of disease, disorder or injury	place to ensure the quality and safety of care was assessed, monitored and improved when needed. The provider had not ensured that the risks associated with continued poor staff practice had been addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not ensured the most current inspection report was displayed on their website. The provider had not ensured their current ratings were displayed on their website.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient staff working at the home to safely meet the currently and changing needs of people.