Alpine Health Care Limited

Alpine Lodge

Inspection report

Alpine Road
Stocksbridge
Sheffield
South Yorkshire
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Tel: 01142888226

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Alpine Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Alpine Lodge is registered to provide accommodation for up to 67 older people. Accommodation is provided over two floors, accessed by a passenger lift. Communal lounges and dining areas are provided. On the day of the inspection there were 49 people living in the home.

Our last inspection at Alpine Lodges took place in 10 August 2017. At that inspection, we found three breaches in the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in Regulation 9; Person centred care, Regulation 12; Safe care and treatment and Regulation 17; Good governance. Following the last inspection, the registered provider sent us an action plan detailing how they were going to make improvements.

During this inspection, we checked improvements the registered provider had made. We found the registered provider had made some improvements but there were repeated breaches in regulations 12, Safe care and treatment and 17, Good Governance. We also found further breaches in Regulations 13, Safeguarding service users from abuse and improper treatment, Regulation 16, Receiving and acting on complaints and Regulation 18, Staffing, because staff did not receive appropriate support training, supervision and appraisal as is necessary to enable them to do the jobs they are employed to do.

This inspection took place on 25 September 2018 and was unannounced. The meant the people who lived at the home and the staff did not know we would be visiting.

There was no registered manager in post at the time of the 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

A new home manager had commenced employment the day of the inspection. Changes within the management team had impacted on the performance of the team. The provider had put in interim management arrangements in place to support the operations and the ongoing improvement of the service. We found from talking with staff this led to confusion about who was in charge.

We received mixed views from people about the support provided to them. Some people and their relatives spoke very positively and told us they felt safe and their support workers were respectful and kind. Other people had concerns about their experience of living at Alpine Lodge.

Staff we spoke with understood what it meant to safeguard vulnerable people from abuse, and records we

reviewed confirmed staff had safeguarding training. However, issues we identified during the day did not support this.

Staff we spoke with told us they felt things had been difficult because of the changes in management and because different managers had told them different things to do. However, staff told us, "Things are getting better."

We looked at the arrangements for the management of medicines. We found medicines were recorded, administered and stored accurately and in accordance with instructions. However, we found that some PRN protocols needed more detail. PRN protocols are to guide staff on how to administer those medicines safely and consistently.

We have made a recommendation about the recording of some medicines.

People were aware of the complaints procedure; however, we saw where concerns had been raised these had been not always been dealt with appropriately or in a timely way.

Activities were provided, however these were not well advertised and displayed for people to see. Further improvements and additions to the activity programme were needed.

People had access to a range of healthcare professionals to help maintain their well-being. A varied diet was provided. However, it did not always consider dietary needs and preferences so people's health was promoted choices could be respected.

Staff told us that supervision took place, however records we reviewed confirmed that staff had not always received appropriate supervision and appraisal.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We found care plans were in place and had been updated since our last inspection. We found for the most part people's needs had been identified. However, records we looked at confirmed risk assessments had bot always been followed to protect people from harm. Accidents and incidents were not always recorded and analysed to identify patterns and trends.

Systems in place to monitor the service had not been completed consistently. The quality and safety audits in place had not always been effective. For instance, the shortfalls that we found at this inspection had not been identified by the registered provider's monitoring systems.

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 safe.

Systems and processes to identify safeguarding concerns were not suitably robust to protect people.

People had individual risk assessments in place but staff did not always follow them to ensure people's safety.

Appropriate arrangements were in place for the safe administration of medicines.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not have access to regular supervision and appraisal for development and support.

Staff had an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People spoke positively about the food but improvements were required to ensure people's nutritional needs were accommodated.

Is the service caring?

Requires Improvement

Areas of the service were not caring.

People gave mixed comments about staff and how they were cared for. Some people and relatives we spoke with told us the service was very caring. Other people and relatives were less positive and had concerns about the service.

Although staff interactions were primarily positive, these were mainly centred around tasks.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were aware of the complaints procedure; however, we saw where concerns had been raised these had not always been dealt with appropriately or in a timely way.

People were not always supported in accordance with their needs and care provided was inconsistent.

Activities were provided, however these were not well advertised and displayed for people to see. Further improvements and additions to the activity programme were needed.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no registered manager in place and changes of management had left some staff unsettled. Some people were not sure who managed the service.

There were quality assurance and audit processes in place to make sure the home was running safely. The systems in place were a little disjointed and needed unifying to ensure people's views are obtained and actively responded to.

We found quality assurance processes were not effective in ensuring compliance with regulations and identifying areas requiring improvement.

Alpine Lodge

Detailed findings

Background to this inspection

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

This inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. This inspection visit took place on 25 September 2018. Two adult social care inspectors and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience in caring for older people and people living with dementia.

Before our inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place. For example, where a person who uses the service experiences a serious injury.

We used information the registered provider sent us in the Provider Information Return. This is information we require registered providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we had received since the last inspection including notifications of incidents that the registered provider had sent us.

Before our inspection, we contacted staff at Sheffield Local Authority and Sheffield Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. All the comments and feedback received were reviewed and used to inform inspection.

During our inspection, we spoke with eight people who lived at Alpine Lodge and five relatives, to obtain their views about the service. We spent time in communal areas speaking with people and observing how

staff interacted with each other and the people they were supporting. We spoke with the regional manager, the business manager, the manager, two nurses, the cook, one activities co-ordinators, the administrator, five care workers and two domestic staff to obtain their views.

We reviewed a range of records, which included three people's care records, three staff support and employment records and records relating to the management of medicines, complaints, training and monitoring quality.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from abuse or harm. Appropriate safeguarding policies were in place for the service but these had not ensured that staff undertook the correct management of any allegations of abuse. The majority of staff had received training in safeguarding and were able to provide information about their responsibilities and the procedures to follow. However, we found the process was not always effective in practice.

Staff were not always aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. When we spoke with staff they were able to tell us that they would report any incidents to the manager. However, one nurse we spoke to told us, "Sometimes it's [safeguarding] too much, like we had a person who had a small bruise to their cheek and the previous manager said it had to be reported to safeguarding. I said the person often moves about and has a risk assessment but we still had to report it."

Where there had been previous safeguarding concerns the systems in place were not effective. For example, there was an incident whereby a person had severe bruising. We saw that staff had been asked to make a statement about this incident. Staff had not completed the required documentation. This meant that some issues had been identified as a risk but not acted upon so people were not safeguarded.

This meant that we could not be assured that staff were aware of the actions they would take if they suspected abuse, or if an allegation was made so correct procedures were followed to uphold people's safety.

The registered provider had a safeguarding adult's referral record which showed that not all incidents had been referred to safeguarding in a timely way or include any records of actions taken or lessons learnt to protect people from abuse neglect or harassment. This meant that safeguarding policies and procedures were not fully embedded and care staff did not always respond quickly enough to concerns.

This showed the registered provider had failed to ensure safeguarding procedures were operated effectively. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulation 13, Safeguarding service users from abuse and improper treatment.

We received mixed views from people about the support provided to them. Some people and their relatives spoke very positively and told us they felt safe and their support workers were respectful and kind. Other people had concerns about their experience of living at Alpine Lodge.

They told us, "There are some very nice people like [care worker] they are very caring but there's some that's not nice" and "They are really kind but they are just rushed off their feet and they don't have enough staff to do everything that's needed and this is why things get missed as they just don't have the time."

Staff knew about whistle blowing procedures. Whistleblowing is one way in which a worker can report

concerns.

We looked at care records and saw individual risk assessments in place so that staff could identify and manage any risks appropriately. We found care records included completed risk assessments giving details of any potential risk to the person and how this risk could be minimised or eliminated. These included risks such as falls or trips.

The assessment assessed the likelihood of harm occurring, how the person would be affected and considered any additional control measures to be implemented to reduce the risk rating. Although a range of risk areas were covered, information was not always being followed to protect people from harm. For example, one person who needed close observations absconded from the home because staff were not following risk assessments that were in place. Failure to follow risk assessments meant that people may be at risk of receiving unsafe care and treatment.

We looked at records of accidents and incidents and found that reviews and investigations were not always sufficiently thorough. We saw when an accident had happened, the cause and effect of each accident or incident was not always investigated. This meant that similar incidents would not be linked together to identify any trends and common causes and action plans put in place to reduce the risk of them happening again.

This showed the registered provider had failed to ensure accidents and incidents were investigated effectively. This was a repeated breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulation 12, Safe Care and treatment.

At our last inspection on 10 August 2017, we found evidence of a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Safe care and treatment. This was because medicines were not always recorded, administered and stored accurately and in accordance with the manufacturer's instructions. The registered provider sent us an action plan identifying actions to be taken and timescales for completion for them to meet the regulation.

At this inspection, we found sufficient improvements had been made to make sure medicines were recorded, administered and stored accurately.

We found medication procedures were in place to guide staff and ensure safe medication administration. We saw most of the procedures were followed by staff. However, we found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, medication prescribed for pain relief. Some protocols lacked detail. They did not explain when to give PRN medication or detail how people presented when they required the prescribed medication. Staff told us some people who lived at Alpine Lodge were living with dementia so were not able to verbally tell staff when they required PRN medication. Therefore, the protocols were required to guide staff to be able to determine if people required any PRN medication. Without this information people may be in pain or agitated and not receive medication as required.

We recommend that the service consider current guidance on PRN protocols and takes action to update their practice accordingly.

We found people's medicines were stored in a clean and secure treatment room. A lockable trolley was used during medicine rounds. The temperature of the treatment room was monitored daily.

There was additional storage for controlled drugs, (CDs) which the law states must be subject to a higher level of security and scrutiny. We checked the stock of all CDs at the home and found it corresponded with the home's records.

There were systems in place for stock checking medication, and for keeping records of medication that had been destroyed or returned to the pharmacy. The staff member we spoke with about medication had a good understanding of the system. The registered provider carried out an audit of medicines every month to make sure safe procedures had been adhered to.

The registered provider had an effective recruitment procedure in place to ensure that people were kept safe. Policy records we checked showed that all staff had to undergo a Disclosure and Barring (DBS) check before commencing work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. In addition to a DBS check, all staff provided an employment history and two references. This showed safe recruitment procedures were in place to keep people safe.

We found that all the care records we looked at included a personal emergency evacuation plan in place for people who may not be able to evacuate the service quickly in an emergency. The plans were specific to each person and completed fully. This meant staff had the necessary information in the event of an emergency.

The home had a dependency tool in place in care records which identified the levels of support they required from staff. We observed staff were present during the day in communal areas. We observed staff interacting with people who used the service however staff appeared to run from one task to another.

People we spoke with and their relatives told us there were not enough staff around. One relative said, " They are really kind but they are just rushed off their feet and they don't have enough staff to do everything" and "There are lots of agency staff on the nursing side so if you ring to ask how he is they say they don't know."

We discussed this with the regional manager and they told us they were continually assessing and monitoring staffing hours provided to ensure the needs of people who met the service were met. We saw evidence the staffing levels were adequate to meet peoples needs.

We found the control and prevention of infection was managed well. The service had policies and procedures in place about infection prevention and control. We saw evidence that staff had received training in infection control.

Staff told us that they had access to personal protective equipment (PPE) (aprons and gloves). Systems were also in place to reduce the risk of cross infection in the service; this included the use of personal protective equipment (PPE) where necessary.

Requires Improvement

Is the service effective?

Our findings

Supervisions are meetings designed to support, motivate and enable the development of good practice for individual staff members. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period, usually annually. Staff gave us mixed feedback about supervisions and appraisals.

Staff had not received regular supervision and appraisal in line with the registered providers own supervision and appraisal policy. For example, the registered provider staff supervision policy dated 8 January 2018 stated supervision should be completed a minimum of six times per year or more frequently if necessary. Staff records we reviewed showed sufficient action had not been taken to ensure each staff member received the minimum amount of supervisions. One staff member told us, "It's getting better, we only used to get supervision when we did something wrong." This meant staff did not have access to appropriate support and supervision.

We checked the staff training matrix which showed that there were staff that had not completed the providers mandatory training. For example, the training matrix showed that 10 staff were overdue mandatory training in moving and handling, 5 staff were overdue in safeguarding training, 7 staff in health and safety and infection control and 22 staff were overdue for emergency first aid at work.

This showed the registered provider had failed to provide appropriate support and supervision. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulation 18, Staffing.

Mandatory face to face training was for more practical sessions. For example, safer people handling. The training matrix also showed training in specific subjects was also undertaken. For example, end of life care training, NAPPI training (challenging behaviour training with an emphasis on positive behaviour support and safe handling of medication.

Staff who had not worked in care before were expected to complete the Care Certificate. The Care Certificate is an identified set of 15 standards that health and social care workers should adhere to in their daily working life. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

We looked at people's care plans and found that they contained detailed information on their dietary needs and the level of support they needed to ensure that they received a balanced diet. Risk assessments such as the Malnutrition Universal Screening Tool (MUST) had been used to identify specific risks associated with people's nutrition. These assessments were being reviewed on a regular basis. Where people were identified as at risk of malnutrition, referrals had been made to the dietician for specialist advice.

People we spoke with told us they liked the food served at Alpine Lodge. One person told us, "The good thing about here though is the meals are good and there's plenty of choice and they always offer visitors

dinner and always make us a cup of tea."

We checked to see if people were supported to maintain a balanced diet. The cook told us people were offered a choice of two meals every day. We noticed from care records a number of people were diabetic. When we asked the cook about how they supported people were diabetic they told us, "I think I have about six diabetics it depends how bad they are to how a big a portion they get, so I ask the nurse and restrict it according to that. This meant there was a risk people's individual dietary requirement may not be met.

We talked to the manager following the inspection about this and they told us that they had already arranged for the cook to access further training in relation to understanding the needs of people's individual dietary requirements.

We saw people were offered protection for their clothes sensitively and people who needed support with eating were given unhurried assistance. We observed lunchtime at the service in the dining room which was where most people ate. The food looked appetising and portions were generous. Staff offered people a choice of meals and everyone had drinks available which were refilled regularly and a variety of cups and beakers were used to suit different needs and aid independence. Staff communicated with people throughout the meal. We observed lunch being served, and it was a busy and sociable experience. Most people chose to eat in the dining room.

People told us and the records we reviewed confirmed people were supported with healthcare. A range of healthcare professionals were involved in supporting people to maintain their health. These included GPs, palliative care nurses, speech and language therapists (SALT) and tissue viability nurses. The care records held clear details of individual's health conditions and the support they needed with these.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We saw the manager held records of DoLS applications and was able to track which stage of the authorisation process a person was currently at. Staff were able to tell us what capacity and consent meant in practice. During the inspection we saw care staff asked for permission first and explained what they were doing before supporting the person with anything. For example, using the hoist or applying clothes protectors at lunchtime. People told us staff always asked them before they did anything, and they were given options of what they wanted to do.

Requires Improvement

Is the service caring?

Our findings

Although observed interaction between people and the staff throughout the day were kind and respectful, the staff were very busy and there was little time for conversation. Care was mostly task orientated and not person centred.

We observed some very mixed interactions between staff and people who used the service. For example, one care worker spoke kindly to people they spoke patiently and waited for an answer. Another care worker went into a person's room without knocking or greeting the person and started to put their laundry away. This meant we could not be sure that people's privacy and dignity was respected always.

People gave us mixed feedback about the staff. One person said, "The best thing about here is the staff are friendly and I feel comfortable with the staff, but they need more of them. Another person said, "The staff are definitely kind. Some staff are nicer and more useful. Some think they know better and I'm not having that. "

Relatives we spoke with told us the staff were caring. One relative said, "They are really kind but they are just rushed off their feet and they don't have enough staff to do everything that's needed and this is why things get missed."

We saw most people were well presented and clean. All assistance with personal care was provided in the privacy of people's own rooms. We saw staff supporting people to their rooms so that health professionals could see them in private. We heard staff speaking to people and explaining their actions so that people felt included and considered.

Most people told us they were listened to and felt their preferences were respected. Although people told us staff did not always respond to their requests in a timely way. For example, people using the service told us, "Sometimes they answer the buzzer quickly and other times it's beyond the pale but not very often" and "You can ring but I'm a person who can't wait long for the toilet once I know I want to go as I can't walk, and I can't wait long for them coming and so it gets very awkward if I'm left a long time and then it's too late and it's not nice".

People who used the service could not recall being involved in their care planning, but none of the people we spoke with wanted to be more involved.
Staff told us that church services were held on a regular basis to ensure people's religious needs were met. On the day of the inspection there was a church service. The care plans contained information about people's spiritual and cultural needs. This meant that people were having their spiritual needs met.

We did not see or hear staff discussing any personal information openly or compromising privacy throughout the inspection.

Requires Improvement

Is the service responsive?

Our findings

People's concerns and complaints were not always responded to in line with the registered provider's own policy. For example, whilst reviewing records for complaints we found that on the 1 July 2018 a relative had made a complaint about finding their relative in a distressed state they made a complaint to the nurse on duty, However the nurse on duty failed to pass this information on to the registered manager and the registered manager was only made aware of the incident in a meeting on the 26 July 2018.

This meant that the registered provider did not operate an effective system for identifying receiving, recording handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

We looked at complaints records and found they were being inconsistently recorded and there was little evidence of lessons learnt to drive service improvement to and used to improve and drive service improvement in a timely way.

This showed the registered provider had failed to have effective systems in place to receive and act on complaints. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulation 16, Receiving and acting on complaints.

There were limited meaningful activities for people using the service. We spoke to people about activities that were on offer. One person told us "There are no activities, but I can't get out of my room until my new wheelchair comes and then I could go down to the lounge and do more maybe but no there's no activities." Another person told us, "There are no activities other than my TV."

We spoke to the activities co-ordinator who told us they had forgotten to put up a list of planned activities. They told us, "There used to be three activities co-ordinators and now there is only two of us and the other activities co-ordinator is off sick.

On the day of the inspection there was a church service being held in one of the lounges. The activity co-ordinator told us that other activities included craft, visits to the local church, day trips out, quizzes and nail care.

At our last inspection on 10 August 2017, we found evidence of a breach of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care. This was because assessments of people's care did not include all their needs, including health, personal care, emotional, social, cultural, religious and spiritual needs.

The registered provider sent us an action plan identifying actions to be taken and timescales for completion for them to meet the requirements of the regulation.

At this inspection we found assessments of people's care had been improved and included all their needs,

including health, personal care emotional, social, cultural, religious and spiritual needs.

The care plans seen contained information about the person's preferred name and how people would like their care and support to be delivered. This showed that important information was available so staff could act on this. The support plans seen contained information about the person's preferences and identified how they would like their care and support to be delivered. The records included information about individuals' specific needs and preferences so these could be respected. This showed important information was recorded in people's plans so staff were aware and could act on this.

There were personal histories recorded for the people in a book called 'all about me', which would give staff an insight into the person's character and personality, this was particularly important as there were a lot of people living at the home who would not be able to share this information with staff due to a diagnosis of dementia or poor health.

Care plans in relation to their behaviour management were personalised and specific to people. They detailed the support staff were to provide, how they should monitor after any incident and who they should contact for additional support if needed. Triggers for the behaviour were documented so staff could recognise them and offer intervention before the person became increasingly anxious or distressed. Care records included information on why people may be presenting with certain behaviours such as experiencing pain, being unwell, being over stimulated or having a low mood. This meant staff were able to manage situations in a consistent and positive way, which protected people's dignity and rights.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems or processes did not operate effectively to assess, monitor and improve the quality and safety of the service and mitigate risks to the health, safety and welfare of people.

The registered provider sent us an action plan identifying actions to be taken and timescales for completion for them to meet the requirements of the regulation become compliant.

At this inspection, we found the registered provider had made some improvements but there were repeated breaches in regulations 12, Safe care and treatment and 17, Good Governance and further breaches in Regulations 13, Safeguarding service users from abuse and improper treatment, Regulation 16, Receiving and acting on complaints and Regulation 18, Staffing.

This meant we could not be assured that the provider had effective systems in place to assess, monitor and improve the quality and safety of the service and mitigate risks to the health safety and welfare of people.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Before the inspection there had been a number of changes in the management team at Alpine Lodge. The provider had put interim management arrangements in place to support the operations and the ongoing improvement of the service. A new manager had been appointed and had started on the day of the inspection. We found from talking with staff this led to confusion about who was in charge.

Staff we spoke with told us, "We are not sure what we are doing, people keep changing the paperwork, we get used to one manager and then they leave." Another person told us, "It's getting better we have got a deputy manager now and they have got a new manager."

The service continued working with the local authority to improve the service. The local authority told us they had started to see some improvements but these had taken time and they were therefore providing continuing support.

The manager told us they conducted monthly in-house audits of all areas of the service, which included accidents and incidents, resident's weights analysis, care plans and risk assessments complaints, safeguarding, medication and staff meetings. Auditing and monitoring of the service was also undertaken by representatives of the registered provider, for example the regional manager. However, when we looked at the audit schedule we found some were not completed. For example, on the day of the inspection we were given the 'In House Audit Schedule 2018' matrix. We reviewed this matrix and it identified that the falls and

accidents analysis had not been reviewed since March 2018. Following the inspection, the provider sent evidence that analysis of accidents and incidents had been completed on another system. This meant there were two systems running alongside each other. This could be confusing and difficult to provide oversight of accidents and incidents and to identify areas of improvement and training required. This shows that systems needed to be formalised and embedded to evidence continuous improvement of the service.

We looked at the management of accidents, incidents and complaints and we could not be confident that the management of incidents, accidents and safeguarding was effective. Whilst care records demonstrated that some accidents had been reported there was a lack of effective systems to ensure there was managerial oversight of accidents occurring at the home.

We discussed this with the provider and they informed us they were in the process of introducing a new electronic risk management system that would enable them to investigate the cause and effect of each incident and to identify any trends and common causes in order to put in place action plans to reduce the risk of them happening again.

Where there was evidence of shortfalls in the safety of people who used the service, the manager was actively trying to address these concerns however there had not been sufficient time for them to effectively address the changes in care that were needed. Our inspection identified that the registered provider was keen to improve the service and we saw that plans were being put in place for this to happen. However, further improvements and evidence of sustained change is required.

This showed the registered provider had failed to have effective systems in place to monitor the quality and safety of the service. This was a repeated breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulation 17, Good governance.

The manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008. They confirmed that any notifications required to be forwarded to CQC had been submitted and evidence gathered prior to the inspection confirmed that a number of notifications had been received.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems did not operate effectively to mitigate the risks to the health ,safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems or processes did not operate effectively to safeguard people from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints systems or processes did not operate effectively to respond to peoples complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not operate effectively to assess, monitor and improve the quality and safety of the service and mitigate risks to the health,safety and welfare of people

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

Systems did not operate effectively to provide staff with the necessary support, supervision and appraisal.