Winchester Care Limited

The Shrubbery

Inspection report

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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

Our inspection took place on 07 March 2017 and was unannounced.

At our previous inspection of 16 March 2016 we found that the provider was not meeting regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 due to there not being adequate staff provided to meet people's needs and keep them safe. During this, our most recent inspection, we found that staffing levels were still inadequate to meet people's needs and to keep them safe.

The Shrubbery is registered to provide accommodation and personal care to a maximum of 28 older people and younger adults who may have Dementia or mental health needs. On the day of the inspection 22 people lived at the home.

There was no registered manager in post. It is a legal requirement that a manager is registered with us. 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.

Similar to our previous inspection we found that there were not sufficient numbers of staff available to meet people's needs or to keep them safe. Risks to the premises had not been identified or managed. People had not been properly safeguarded from the risk of abuse and degrading treatment from other people. Medicine systems required some improvement to promote safety. Overall, safe recruitment processes were in place.

The provider had not ensured that the overall service was caring as they had not taken action to ensure that people were safe or lived in an environment that promoted people's dignity. The individual staff who supported people had a kind and caring approach and treated people with dignity and respect. People were supported to maintain their independence where possible. Visiting times were flexible to enable people to have regular contact with their family and friends.

The main meal time was not a pleasant experience for people. Although there was a choice of meals people were not appropriately informed of what these choices were. Staff told us that they received an induction when they started to work at the home, on-going supervision and that they were supported well. Staff confirmed that they had the training that they required. Staff asked people for their consent before they provided any care or support. Where restrictions were used to keep people safe the provider had ensured that the actions taken had been approved by the local authority.

Complaints procedures were available but not in a user friendly format. Complaints received had not always been logged appropriately. We were unable to ascertain if people had been given the opportunity to feedback on the service they received. There was a lack of meaningful activities available for people. People and their relatives were involved in the planning and review of their care.

Quality monitoring and audits had failed to identify that a number of areas of service provision were not meeting the requirements of the law. People were at risk of harm and injury and no action had been taken to address this. The provider had failed to notify us of issues that they were required to by law.

You can see what action we told the provider to take at the back of this report.

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

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.

There were insufficient staff available to meet people's needs or to keep them safe.

The provider had not ensured that the premises were safe and free from hazards.

People were not properly protected from abuse or degrading treatment from other people.

Medication records were not always accurate which meant the provider could not evidence that medication was given safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The mealtime was not a pleasant experience for people. People were not always supported enough to keep them safe at mealtimes.

Staff told us that they had received training and supervision to support them in their role.

Staff ensured that people gave their consent before they delivered care and support.

People had access to healthcare support to maintain their health and wellbeing.

Is the service caring?

Requires Improvement

The service was caring.

The provider had not ensured that the service was inherently caring as they had failed to ensure that people were kept safe and treated with dignity and respect.

Individual staff were kind and caring towards people.

People and their relatives were supported to be involved in care planning.

People could receive their visitors at any time. Visitors to the home were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of meaningful activities available for people.

People were not always informed on how to make complaints.

People were involved in the planning and review of their care. Staff had some knowledge of people's care needs.

Is the service well-led?

Inadequate

The service was not well-led.

Quality audits and monitoring had failed to identify that people were at risk of abuse and injury.

There was no registered manager in post as required by law. The day to day management arrangements were ineffective.

The provider failed to inform us of issues that they were required by law to notify us of.

The Shrubbery

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.

This inspection took place on 07 March 2017 and was unannounced. The inspection team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. This included notifications sent to us by the provider. Notifications are forms that the provider are required to send to us to inform us of incidents that occur at the home. We also requested information from the local authority [who purchase care on behalf of people] for this home.

We spoke with eight people who lived at the home, two relatives, four members of staff, the newly appointed manager and the provider. As some people were unable to tell us their views of the service, we used a 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 looked at care records for three people, three staff recruitment files, accidents and incident records and complaints received. We also looked at nine medication records, staff training records and quality assurance audits completed by the provider and staff.

Inadequate

Is the service safe?

Our findings

A relative shared with us, "There are definitely not enough staff. There are not enough staff to look after people all of the time". A person told us, "I have to wait, wait, wait". Another person told us, "I'm not bothered. I don't need staff, I look after myself". A staff member told us, "There are not enough staff. We [the staff] are stressed and pressured a lot of the time". Another staff member shared with us, "There are not enough staff. I don't think we can keep people safe".

At our previous inspection of 16 March 2016 we found that the provider was in breach of the law concerning staffing levels. We reflected this in our report and required that staffing levels improved. At this, our most recent inspection, the provider told us that they had increased staffing levels but had recently decreased them again as a lower number of people now lived at the home. The provider told us that they had not used any method to determine the number of staff required. This meant that the provider had not considered people's dependency levels and/or needs when they decided how many staff were needed.

A relative said, "I come here sometimes and it's pandemonium but it's rare". Our observations were that throughout the day the atmosphere in the home was chaotic. Staff were rushed when they tried to keep people safe from a person who displayed unsettled/distressed behaviour. The person shouted intermittently throughout the day and at one point threw their walking frame across the lounge. At lunch time a person barricaded the dining room door and would not let staff in and out. The meal took an hour to serve. This incident was similar to one we observed during our previous inspection when a person was trying to eat a button off their cardigan. This showed that the provider had not reflected and learnt from previous experiences to reduce the chance of another similar event re-occurring. We saw a person prod another person with a fork and we saw people moving the tables. The staff did not notice these incidents. We observed a 12 minute period when there were no staff in the lounge. During this time we saw a person try to stand as there were no staff to assist them. The person looked unsteady and was potentially at risk of falling. We heard another person ask for the toilet and staff had to ask them to wait. A staff member told us, "Today is a fairly typical day". This demonstrated that the provider had not made improvements regarding staffing levels and people were placed at risk of not having their needs met or being safe.

This is a continued breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014.

A person shared with us, "I am safe here". A staff member said, "I don't think that people here are always safe". We found that the provider had not ensured safety.

There were obvious visual risks that had not been identified or acted upon that could have placed people at risk of accident and injury. We noted that there was exposed pipe work in one bedroom and down the stair case [that looked like a handrail] we felt these pipes and they were very hot to touch. This meant that for people who may use the stairs there was a risk of a burn if the pipe was mistaken for a hand rail, or from falling if a person recoiled from touching the hot pipe. The provider told us that they had not noticed the hot pipes. The carpet on the landing was loose as it had not been properly fitted and was a potential trip hazard. Some people invited us into their bedrooms to speak with them. We saw that wardrobes had not been

secured to the walls. This meant that there was a potential risk that they could fall over on top of a person.

The premises had been fitted with a fire alarm. However, evidence was not available to confirm that the weekly tests of this equipment had been undertaken. Evidence was not available to confirm that the fire alarm system had received an annual service. We fed those issues back to the local authority who had a contract with the provider. On receipt of our feedback the local authority health and safety advisor visited the home to assess the risks to ensure people's safety. They provided us with a detailed report that included photographic evidence. The report detailed a number of other issues that included, a nail protruding from a carpet, failure to undertake a risk assessment for legionella [a water borne infection] and a lack of evidence relating to the service and testing of the fire alarm panel and weekly fire prevention tests. We brought these issues to the attention of West Midlands Fire Service who also visited the home to instruct the provider. The provider had not taken action to determine the safety of the premises resulting in people being placed at risk of potential harm and/or injury.

Failing to ensure that the premises are safe is a breach of regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

A person told us, "I have my frame to help me walk". We saw that risk assessments had been undertaken relating to the moving and handling of people and mobility assessments had been completed to promote people's safety. Where people had mobility issues a referral had been made to occupational therapy for assessment and the provision of equipment. We were told that one person had experienced a recent fall that had resulted in a fracture. Another person had extensive bruising to their face also caused by a fall. Accidents and injuries had been documented, however, a monthly analysis of the falls and accidents had not been completed for three months. The provider told us that they had not had time to complete this. An analysis would give quick reference to all falls and injuries to enable the provider to determine patterns and trends to prevent being at risk of further incidents.

A person told us that they had not experienced poor treatment they commented, "Not that I know". A relative said, "No abuse as far as I know". A staff member shared with us, "If there were any concerns I would report them straight away". Other staff told us that they knew what action to take if they suspected that someone was at risk of harm. Staff also told us and records confirmed that they had received training on how to identify abuse and report concerns.

Our observations confirmed that some people did not feel protected from abuse. One person told us that they had been physically harmed by another person. They said, "I do not feel safe here. The person is still here. I am scared to go down stairs so I just stay in my bed every day". This incident had been reported to us and the local authority safeguarding team as is required. However, the person still did not feel protected from further harm. Another person said, "I go up to my room at six o'clock I get out of the way of them [people who displayed unsettled behaviour]". Throughout the day we witnessed one person using foul language and on some occasions directing this at other people. The language used was intimidating, aggressive and degrading. People's expressions showed fear and they were restless. Records that we looked at highlighted that this behaviour was not a one off. People had been subjected to this over a period of weeks in addition to a number of occasions when they had been spat at. A person told us, "They [the person] don't know they're swearing. One thing I don't like is spitting". Staff confirmed that our observations had reflected a typical day. The provider told us that he had delivered feedback on the issues to the person's funding authority but had been told that nothing could be done until May 2017. This meant that the person had continued to verbally abuse, intimidate and degrade other people who lived at the home.

Failure to protect people from abuse is a breach of regulation 13 HSCA 2008 (Regulated Activities)

Regulations 2014.

A person shared with us, "They [the staff] deal with my tablets and make sure I take them". Another person said, "They [the staff] bring my tablets twice a day". A staff member told us, "People's medicines are well managed. It is important". We observed that staff sat by people when they supported them with their medicines to ensure that they had swallowed them.

However, we found that medicines had not always been managed safely. A staff member said, "A few days the temperatures have been too high". Records that we looked at highlighted that on a number of days the temperature of the room where the medicines were stored exceeded those recommended by the manufacturer. This meant that there was a potential risk that some medicines may not work as they should to treat people's conditions. The provider told us that they were aware of this and was looking at options to rectify the situation.

We read a medicine label that stated that it was short life produce only and should be discarded within a set number of days. However, the staff had not documented the date the medicine was first opened so would not be able to determine when the medicine should be discarded. This meant that there was a risk that a person could be given medicine that had passed its use by date. We found that one person's medicine patches had not been recorded correctly. This meant that there were 28 more patches available than records confirmed. Staff confirmed that the person had their patches applied and their medicine record confirmed this.

The remainder of the medicine records that we looked at had been completed fully. Where records were handwritten two staff had signed to confirm that the information was correct. We found that where medicines had been prescribed on an 'as needed' basis there were protocols in place to instruct staff when they should be given. This practice is recommended good practice by professional bodies and is a way of ensuring medicines are managed safely.

People were mainly protected by safe recruitment practices. A staff member told us, "All my checks were carried out before I started work". Other staff also told us that prior to starting work they were required to provide references and complete a check with the Disclosure and Barring Service (DBS). We checked three staff files and saw that these checks had been made. The new manager told us that their DBS had been undertaken by their previous employer and was over three months old. They told us that they were to apply for a new DBS via us, The Care Quality Commission, as is the requirement for registration. However, the provider informed us that in the interim they had not undertaken a risk assessment as is required.

Requires Improvement

Is the service effective?

Our findings

The main meal time was not a relaxed or pleasant experience for people. There were inadequate numbers of staff to provide support consistent with people's needs. One person took and ate the meal another person had been served. This could have placed the person at risk if they had food that they should not if for example, they were diabetic or they were prone to choking. Staff did not notice these incidents.

The tables had not been laid. Staff gave people knives and forks when they gave them their food. There were no condiments or serviettes available. A person said, "The food is lovely but I do not know what we have got today". The menu had been written on a chalk board that was secured to the wall at the rear of the dining room so was not accessible to all people. There was no pictorial menu used to aid people's understanding of the meal choices on offer. We heard staff asking people what meal they would like. However, they did not show people the meals so that they could make an informed choice. One person looked confused when staff asked them what they wanted to eat and just pointed to the meal the person next to them had. They did not eat their meal. We saw that staff put gravy on every person's meal without asking them if they wanted it. We went with staff to take a meal to a person who stayed in their bedroom. The person wanted to eat their meal in bed. As no table was available we observed that they had to lean over the side of the bed and put their plate on the floor to eat their food. A staff member said, "They have their meal in bed every day. We all know that so there should be a table".

During the day we saw that staff offered people drinks and snacks regularly and encouraged people to drink. We saw that risk assessments relating to eating and drinking were undertaken. Staff we spoke with were aware of people's food and drink preferences and dislikes and people's risks regarding eating and drinking. Staff told us and records confirmed that people were weighed frequently and where there was a risk of weight loss people had been referred to the dietician.

A person shared with us, "I think the staff are trained because they're confident". Another person said, "The staff are not too bad. They have a bit of training but they don't talk to us about it". A staff member commented, "I have had all of my training". Other staff we spoke with agreed with this. As the staff training matrix was not available on the day we asked the provider to email this to us. To date, we have not received this information. Our data base highlighted 'better than expected' for staff attainment in nationally accredited care awards. This meant that staff could have received the training and knowledge they required to look after people appropriately. However, we could not confirm this from what we observed during the day.

A staff member told us, "I had induction training when I started work here. I was shown around the premises, I looked at records and care plans. I was introduced to the people and other staff and then I worked with experienced staff to see what I had to do". The provider had introduced the Care Certificate. This consists of nationally recognised induction standards for care staff. The Care Certificate gives staff the knowledge they require to provide safe and compassionate care.

Staff told us that they had received supervision with previous managers to discuss their work and identify

any training needs. One member of staff said, "We have supervisions every three months. We discuss our goals and if we are happy and I can get feedback on my work". Staff confirmed that they could telephone the provider out of business hours if they required support.

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. 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).

A person told us, "The staff always ask me before doing anything". A relative told us that staff asked their family members permission before providing support. They said, "The staff are very considerate". We observed that staff asked people to consent to everyday tasks. We heard a staff member ask a person if they would like to move into an easy chair and if a person would like to use the toilet. We saw that staff explained to people before giving them their medicines. On each occasion people either consented verbally or implied their consent by gesture or action. For example holding their hand out or opening their mouth for their tablets. This showed that staff were working within the principles of the MCA.

We had been made aware by the local authority that the provider had on one occasion used a method that was 'not the least' restrictive. This issue had been discussed in a local authority meeting and the matter has since been closed. The provider told us and records confirmed that people's capacity to make certain decisions had been assessed. We saw that applications to deprive people of their liberty had been made appropriately and that staff had worked alongside the local authority to ensure that people were not unlawfully deprived of their liberty.

A person told us, "If I am ill the staff call the doctor". A relative told us, "All professionals are involved when needed". We saw a district nurse visit during the day to treat a person. People told us that they had access to dental and optician services. Other people told us that they had been offered the influenza injection. One person was not well. They had been seen by their doctor but the staff were concerned about the person's health. During our inspection they called the paramedics to assess the person to prevent their condition worsening. This showed that the provider ensured that people had access to regular and emergency health care services.

Requires Improvement

Is the service caring?

Our findings

A person shared with us, "They [the staff] are alright. They are there if you want to talk. They get you what you want, [staff name] is more like a big sister". Another person said, "I get frightened I'll get confused and embarrass myself and they [the staff] are helpful". A relative told us, "They [the staff] are very caring about the people. They get to know them". Another relative said, "I wouldn't like to put her [person's name] somewhere else. They [staff] seem very nice to them [people]". Staff we spoke with told us that their colleagues were all caring.

We heard staff asking people, "Are you alright" and, "Do you need me to help?" We observed that staff had a caring approach. We saw that that they displayed warmth when interacting with people and that people were smiling when staff were with them. Whilst we found that the individual actions of staff were kind and caring our observations established that the provider had not promoted a caring environment as they had not protected people from experiencing harm from other people.

A person told us, "I choose what time I get up each day". Another person said, "I go to bed when I want to". Relatives we spoke with confirmed they were involved in their relative's care. One relative told us, "I am involved at all times". A staff member shared with us, "We [the staff] enable people to make their own decisions by giving them information and options". We saw that information was available in care plans about how people liked their support to be provided.

A person told us, "The staff knock my door". Another person shared with us, "I like to spend time alone and I do that". A relative confirmed, "She [person's name] likes to sit in this room [a small lounge] because she prefers it on her own". Staff told us that they promoted people's dignity by ensuring that they were covered when they supported them with their personal care. We saw that the preferred name for each person had been determined and recorded on their care file. We heard staff referring to people by their preferred name. This showed people respect.

A person shared with us, "I do everything myself. I don't need any help". Another person said, "I can have a bath and a shower on my own. They [the staff] are always there, but not in the bathroom. If I need help to do something I can always ask them". Staff told us that they encouraged people to maintain their independence where possible.

People told us that they could have visitors at any time. A relative said, "I come here nearly every day". Another relative told us, "I am made to feel welcome". Staff told us that visiting hours were not restricted and that people could welcome their visitors at any time in the lounge or their bedroom for privacy.

Independent advocates had visited the home annually. The advocacy service had been contracted by the local authority to support people to complete their questionnaires about their experience of living at the home. Although we saw that information was displayed about advocacy services and the staff were aware of how to support people to access this service if this was required. Not all people were aware what an advocate was. An advocate can be used when people have difficulty making decisions and require this

support to voice their views and wishes to ensure that they live their life in their preferred way.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently have access to activities that would meet their needs. One person told us, "I am fed up". Another person said, "I like doing the garden. I have asked but they [staff] have not got me what I need". As at our previous inspection of March 2016 people and the relatives we spoke with told us there were a lack of activities. At this, our most recent inspection, staff told us that eight people, through their own choice, stayed mostly in their bedrooms. We met five people who staff confirmed were people who stayed in their bedrooms most of the time. Staff told us that those people would be able to access the community with support from staff and partake in a wide range of activities. There was little interaction or engagement for these people apart from staff checking on them intermittently and offering them meals and drinks. A staff member told us, "There are not enough staff to do anything with them [the eight people] like taking them shopping. They are mostly able and most would like that". Staff told us that activities took place that included listening to music and singing. During the day we heard music playing. We saw one person folding the laundry. They smiled and told us that they liked doing that. However, most people spent long periods of time with nothing to do. As with our previous inspection we saw that people spent much of their day sleeping with little interaction with others.

People felt confident to raise concerns however, documents and process to support people were not available. A person said, "I would tell the gaffer [provider] if I had a complaint". Another person told us, "I don't want to complain. If I've got something to say, I can talk to the staff. I had a problem, I mentioned it and they're sorting it". We saw that a complaints procedure was available in the 'service user guide'. This is a document given to people before they moved into the home to them aware for example, of what their rights are and the level of service that they could expect. Although we asked we were not provided with an easy read complaints procedure. An easy read complaints procedure is produced in different formats for example large print, or with some text represented by pictures or symbols to ensure that it is easier to read. We read a complaint that had been made by a relative. It had been documented in a person's care notes rather than in the complaints book. Although it had been looked into and action had been taken to address the issue the provider told us that they were unaware of the complaint. The complaints procedure for staff instructed them to record all 'written' complaints in the complaint book. It did not instruct them to do the same for verbal complaints as was the case with the complaint. This meant that there was a potential risk that verbal complaints maybe overlooked or not dealt with fully or appropriately.

A person told us, "Before I came here I was asked lots of questions". Another person shared with us, "I answered some questions when I was coming out of hospital". A relative told us, "An assessment was carried out to make sure that the staff could look after them [person's name].
Records that we looked at confirmed that an assessment of need had been undertaken and that a care plan had been obtained from people's funding authority. This information would enable the provider to decide if they could meet a person's needs.

A person said, "They [staff] review me. I have been to meetings they [staff] talk with me, about me and sign. I don't care what is written about me though, I am not interested. That I can do my own thing is all I am bothered about". A relative told us, "I am invited to attend reviews". Another relative said, "The reviews are

good. I am listened to". Records we looked at showed that reviews of people's care needs took place. Staff we spoke with were aware of people's current needs and people told us that they felt that staff knew them and their care needs well.

A person said, "The staff know what I like and do not like". A relative told us, "The staff know their likes and what they dislike". Staff we spoke with had a good understanding of people's likes, dislikes and preferences with regards to their care. We asked staff about the people whose records we had looked at. The staff told us in detail about people's health conditions, the support they required and the activities they enjoyed. Records that we looked at held personalised information about people that included; family contacts, where they worked previously, what they enjoyed and their preferred daily routines. This helped staff to know how to support people.

Inadequate

Is the service well-led?

Our findings

Although there had been a change of company name a few years previously, the provider was the same. The provider had a history of ineffective monitoring and audit processes. Our report of June 2016 stated, "The system for auditing had not been effective in reducing medication recording errors. Audits completed on care plans had not identified that there was conflicting information about people's needs. The audits had not been effective in ensuring that records held about people were up to date and accurate".

Systems and processes were not in place to enable the provider to operate effectively to ensure the service was led and was meeting regulatory requirements. During this, our most recent inspection, we found that although obvious risks to people's health and safety were clearly visible, exposed hot water pipes that had a potential to burn people and ill-fitting carpets that had a potential to cause people to fall, the provider had failed to identify these during their audits of the premises. They said, "I had not noticed those things". The provider had not realised that fire safety issues were apparent these included, the fire alarm system had not received a service to ensure that it would work properly and a lack of evidence to confirm that fire drills were undertaken. These issues should have identified during routine audits of the service but had not been. This showed again, that the systems in place to audit and check the safety and quality of the service had not been effective and the safety of people had not been assured.

We found that there were poor outcomes for people. We identified in our previous inspection that there was a breach of the law as staffing levels were inadequate. At this our most recent inspection the provider told us that they had not used a tool or guidance to determine how many staff were required. We observed instances when there were not enough staff to supervise people. to support and reassure them when needed and to help keep people safe. During this time a person tried to stand without assistance and looked unsteady so was potential risk of a fall. Another person put paper in their mouth that could have potentially been a choking hazard. We found that people had been verbally abused and intimidated by another person. We found that a person stayed in their bedroom as they were afraid to go downstairs as they had been hit by another person the year before. We found that the meal time experience was not positive as people were not always informed appropriately the meals offered and there was a lack of supervision.

A staff member told us, "If I saw anything I would feel happy to report it". Staff we spoke with were aware of how to raise concerns and knew how to whistle blow. We saw that a whistle blowing policy was available for staff to follow. However, they had not informed external agencies of the person to person abuse that had occurred most days in the home.

A person shared with us, "I completed a form". A relative told us, "Yes, I've done two or three [provider feedback forms]. I don't think I've ever had anything to grumble about". At our previous inspection people and their relatives told us they had not been invited to give feedback on the service. During this, our most recent inspection, the provider informed us that they had used questionnaires to determine people and relative satisfaction with the service. We asked the provider if we could view the completed surveys and the analysis. They told us that they did not have this information on site but would email it to us. To date we had not received this information.

Failing to have effective systems to assess, monitor and improve the quality or safety of the service provided or, failing to assess, monitor and mitigate the risks relating to the health, safety and welfare of people is a breach of regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

Notifications are forms that the provider is required by law to send to us to inform us of incidents that occur at the home. Our guidance states, "Notifications must be submitted without delay". The provider told us that they had not realised that a notification was required. The provider had failed to inform us that a person had a recent fall that resulted in a fracture.

The provider told us that most people had a Deprivation of Liberty Safeguarding [DoLS] authorisation. Yet they had failed to inform us about these. It is a legal requirement that we are notified of every DoLS authorisation. The provider told us that they thought that the previous manager had notified us all DoLS authorisation and had not checked to see if they had completed that task.

Failing to inform the Care Quality Commission of Deprivation of Liberty Safeguarding authorisations and serious injuries is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider had been running the home intermittently. When we provided feedback on our inspection findings the provider told us, "I am out of my depth. I have had some training and am having some more. I have had to secure a consultant to support me".

It is a legal requirement that a manager is registered with us. The registered manager left the home in January 2017. A new manager was recruited but did not stay long. Another manager started work the day before our inspection. The new manager told us that it was their intention to apply to be registered with us. A person said, "Yes. There was a woman who was acting as a manager and she went. I was upset. I was just getting used to it". A staff member said, "It is difficult to have any consistency. We have had three managers now in a short time". Other staff also told us that they had found it hard with so many different managers over the last year.

We found that there was some satisfaction. A relative shared with us, "I'm very satisfied with what goes on here". A person told us, "It is well-led". We saw the provider speak with people during the day. It was clear that people knew who the provider was. They looked comfortable to chat with him. A number of people knew who the provider was. A person shared with us, "He is alright, he is [providers name]". Another person said, "The head staff's a woman. I can't think of her name. The owner is a bloke. He comes in now and again".

It is a legal requirement that our current inspection rating is made available. We saw that there was a link on the provider's web site to our last report and rating and the report was on display within the premises. This showed that the provider had met that legal requirement.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider had failed to notify us of all Deprivation of Liberty Safeguarding approvals and serious injuries that had occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (d) HSCA 2008 (Regulated Activities) Regulations 2014. The provider had failed to assess, monitor and mitigate risks within the premises relating to the safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) (c) HSCA 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that people were protected from harm and abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance Regulation 17 (1) (2) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2014. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (HSCA 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that an adequate number of staff were made available to meet people's needs and to keep them safe.