Essex County Care Limited

Ramsay Manor

Inspection report

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Ramsey,
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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

Overall summary

This unannounced inspection took place on 01 December 2015. Ramsay Manor is registered to provide accommodation and personal care for 84 people, there were 18 older people living in the service when we inspected.

Ramsay manor was placed into 'Special measures' by CQC following the last inspection in April 2015 as they were not meeting the legal requirements. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin

Summary of findings

the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Following the last inspection the provider had sent us a detailed action plan which set out what they intended to do to meet the legal requirements. At this inspection we found that some improvements had been made but the provider had not achieved all that they said that they would do. We found that some actions had not been undertaken as planned and others had not been fully implemented. The service did not meet all the legal requirements for the 18 people currently living in the service. We were told that the provider was planning to admit more people and have concerns about the impact of increased numbers on the people already living at the service and the quality of care.

Since the last inspection a new manager has been appointed and has taken up post. They told us that they had applied to CQC to be registered. 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.

We found that the service was only partly open; areas of the building were closed to people and staff as a refurbishment was underway. At the last inspection we found that the layout of the service and the on call system did not promote peoples independence or wellbeing. We found continued problems in these areas. The building also presented significant challenges in terms of staffing due to its size and layout. We found that staff were not always deployed effectively and people had to wait for assistance.

Safety checks were completed but the risk assessments processes were not always effective. We were concerned that the lack of clarity around moving and handling processes could lead to a risk of injury.

Medication was not safely managed. We found issues with the storage and the administration of medication. People did not always receive their pain relief as prescribed.

Since the last inspection significant recruitment had taken place and we found that the provider operated a safe and effective recruitment system. New staff however did not receive a comprehensive induction. Staff knew what abuse was and although they were not all clear about the role of the local authority they knew that concerns should be reported.

We saw that staff were supported to access ongoing training but their understanding of the subject and competency was not accessed. We identified shortfalls in staff understanding of consent, medication and moving and handling. The guidance for staff to follow to meet people's health needs was not always clear.

People enjoyed their food and received a varied choice of nutritional meals. Support was available for those who needed it

Staff were caring and treated people with kindness. However people's involvement in decision making was inconsistent. Dignity was not always well understood.

Care plans were in place but they were not always easy to use. This combined with the high numbers of new staff meant that people were at risk of not having their needs and preferences met.

Activities were being undertaken which was a positive development. However further efforts should be made to ensure that they are accessible to all the people living in the service, including those people with a diagnosis of dementia.

The new manager was being supported by an independent consultant and staff were largely positive about the changes that had taken place. Some efforts had been made to consult with people but audits were not well developed. The concerns which were identified at this inspection had not been identified by the registered person

Summary of findings

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

We continued to have concerns about how equipment was being used and how risks were identified and managed

Medicine administration did not always follow professional guidance.

Staff did not always respond to people's needs and requests in a timely way

Is the service effective?

Requires improvement

The service was not consistently effective.

Training was provided to staff but the system for checking their understanding of what they had learnt did not work effectively.

There were gaps in staff skills and knowledge. Consent was not well understood

Staff did not always fully understand the health conditions of the individuals they supported

People were supported to have sufficient to eat and drink

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff interacted with people well and were patient.

Dignity was not always well understood

Care plans did not set out people's choice for when they reached the end of their life.

Is the service responsive?

Requires improvement

The service was not consistently responsive

Care delivery was not always personalised and or corresponded with the plan of care

People enjoyed the activities on offer but further development is needed to ensure that they meet the needs of people with dementia.

Is the service well-led?

Inadequate

The service was not well led

Poor practices were not being identified and addressed.

Audits did not address the inconsistencies in the approach of staff or promote individualised care.

Ramsay Manor

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 the 01 December 2015 and it was unannounced. The inspection team consisted of four inspectors.

Prior to the inspection we reviewed the information we held about the service and safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

There were 18 people living in the service but two people were in hospital. We spoke with eight people, one visitor, and a healthcare professional. We spoke with six staff, the manager, a supporting manager and an independent consultant who was working with the provider. We looked at staff records; peoples care records, staffing rotas and records relating to how the safety and quality of the service was being monitored.

Inadequate

Is the service safe?

Our findings

At our previous inspection in April 2015 we found that the provider was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had concerns about the safety and suitability of the premises and equipment. At this inspection we found that there was a refurbishment underway and areas of the service were closed to staff and people living there. We did not visit these areas as part of the inspection and focused on the ground floor of the service where people were living. We continued to have concerns about how equipment was being used and how risks were identified and managed.

The communal areas were a significant distance from people's bedrooms which could place people at risk of fatigue. There were also areas of the service that had differing floor levels which made it difficult for people with dementia or poor mobility to negotiate. We considered that people were at a higher risk of falling in these areas of the service. No further action had been taken by the provider to help differentiate the flooring levels for people with poor eyesight and/or mobility needs using walking equipment. This had also not been considered by management when they recently reviewed the environmental risk assessment.

At our last inspection we reported that the call bell and intercom arrangements were not working effectively for people with impaired hearing, communication difficulties or dementia needs because they were either unable to use it or unable to communicate effectively with staff through it. This meant people were not always able to call staff when they needed them with the equipment available. The provider told us that since the last inspection the equipment has been reprogrammed and staff provided with training to ensure that they were able to pick up when there was more than one call in the system.

Some people had call pendants around their neck but not everybody was aware of what they were for or remembered to use them. We rang the call bell for one individual who was calling out for help, staff responded by speaking through the speaker which sounded in the individuals room. The individual did not know where the noise was coming from and did not respond. The member of staff walked to the individual's room to assist them. We saw that risk assessments had been undertaken for those unable to use the call bell system and were told that hourly checks were made to those individuals in their rooms. We observed one individual calling out for help, on a number of occasions throughout the day of the inspection and we remained concerned that alternative systems/methods had not been considered.

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

We saw that checks were undertaken on fire safety equipment to ensure that it was working effectively. There were records to demonstrate that fire drills were being undertaken and that checks were undertaken to monitor the temperature of the water to reduce the likelihood of injury. The manager told us that a risk assessment had been undertaken to identify the risks regarding legionella but the report was not yet available.

We looked at the equipment used for manual handling and found that the hoists and the stand aid had been appropriately checked in line with relevant health and safety regulations (Lifting Operations and Lifting Equipment Regulations). There were three hoist slings in the storage area; two 'full body' and one access sling, none of the slings had a label indicating that they had been LOLER checked however the manager assured us that they had been.

Risk assessments lacked detail on how people were to be supported to minimise or prevent risks.

Moving and handling assessments were in place but they did not all document the size or type of sling which was suitable for individuals or how the loops should be used. This lack of clarity could lead to confusion and risk of injury if individual were placed in the wrong size sling. Some individuals had been assessed for different types of equipment but it was unclear how staff should determine what to use. There were risk assessments in place for some individuals who had bedrails but we could not see that alternative and less restrictive methods of keeping the individual safe had been considered.

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

At our previous inspection we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicines were not always safely managed. At this inspection we found continued poor practice. We observed a member of staff signing to confirm that medication had been taken

prior to administering it to the individual, which did not take into account that they may change their mind. We also observed a member of staff signing to say that medication had been offered and refused when we did not observe this. We were concerned that people were prescribed pain relief and were not receiving it. We asked staff to assist an individual who was calling out, and told us that they were in pain. We later noted that pain relief had been administered however the time that this was given was not recorded. The member of staff signed over the "refused" code already entered in the box on the medication administration record corresponding to an earlier time. Managing medication in this way meant that people were at risk of overdose because staff could not be assured of the timespan between doses administered.

Written plans were being put in place to enable staff to make consistent judgements regarding the use of medicine prescribed on an, 'as required basis' (PRN). The plans that we looked at had not been written in sufficient detail to enable staff to make a judgement about whether medication was required. For example the plans for an individual with a diagnosis of dementia who had been prescribed pain relief did not identify how the individual may show signs of pain.

There was no system in place to manage or oversee the administration of creams and lotions. The medication administration record recorded that these were applied in the person's room. Staff told us that they recorded in the daily records but this was not being consistently undertaken. The directions as to where and when the creams should be applied were not clear, as most creams said as directed.

Medication was not stored securely for although the door was locked the room was not secure because the window, on ground level, was wedged open to provide ventilation and therefore accessible to people from the outside. It was wedged open because the sash was broken; the window was in need of repair and redecoration. Room storage temperatures were monitored

Stocks of a sample of medicines were checked and found to be accurately recorded in all but one example, where medication had not been correctly booked in. Staff administering medication ensured people had a drink and gave people the time they needed to take their medication.

Overall we found that medication was not safely managed and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Accident forms had been completed when people had fallen and people were referred to and seen by the falls prevention team. However in one example we looked at, the risk management plans had not been revised to guide staff on what to do address factors that may contribute to the risk as advised by healthcare professionals. The risk's identified for this person included poor fitting slippers, the fact that they did not use call bell and how to support them in terms of their sight and balance. Their risk management plan did not have sufficient guidance contained in order to ensure staff could effectively manage this person's risks.

This is a breach of regulation 12 (2) a and b of the Health and Social Care Act 2008 (regulated activities) regulations 2014

Staff were appropriately recruited but were not deployed in a way that ensured that people's needs were consistently met. Since the last inspection we saw that there had been a recruitment drive and 18 new care staff had been recruited in the last six months. The provider had robust systems in place to recruit and select new staff. Staff were only employed after required checks had been completed to ensure that they were suitable to work with vulnerable people and appropriate to carry out their role.

At the time of our inspection only the ground floor of the service was being used to accommodate people. The logistics in relation to the layout of the ground floor was a challenge because it spread across a distance with a number of connected zones. Although there was eight staff on duty to care for 16 people, we found people did not always receive the support they needed in a timely way. Two of the eight staff were senior carers who spent the majority of their time in the office on paperwork and making telephone calls and therefore were not available to support care staff. On two occasions we observed people having to wait unnecessary and for long periods of time for staff to get from one area to another to take them to the toilet. We observed one individual requesting to go to the toilet and we noted that were told that they would have to wait as they needed two staff and only one was available. The individual became agitated about having to wait and then tried to transfer themselves between the chair and wheelchair with the assistance of one member of staff.

Inadequate

Is the service safe?

They almost fell between the chair and wheelchair and we heard them saying to a staff member, " I am sorry that I am such a nuisance." We were concerned that staff were not deployed effectively to meet people's needs.

The manager, supporting manager and consultant for the provider told us that staffing levels were calculated according to people's dependency levels. They told us, and it was stated in their action plan that the Residential Forum, a workforce planning tool was used and this was managed by head office. They were unable to show us how other factors such as the layout of the home and accessibility of facilities, competencies and experience of staff particularly in relation to the high number of new staff, social and recreational activities for people using the service were considered to ensure validity of results.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (regulated activities) regulations 2014

Staff members demonstrated a good understanding of their responsibility to report concerns in relation poor practice and potential abuse and stated they would whistle blow if the need arose. Staff said they would talk to the manager but some were not aware of other ways to raise safeguarding concerns for example to the local authority who take a lead in this area.

Requires improvement

Is the service effective?

Our findings

At our previous inspection in April 2015 we found that the provider was in breach of Regulation 12 (2) c of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found that the training which was provided did not equip staff to meet the needs of the people living in the service and keep them safe.

At this inspection we found some improvements but we continued to have concerns about the quality of training and how the provider oversaw the competency of the staff.

We saw that there was a staff training plan was in place and the core training subjects required for the role was delivered by the providers training team. The training folder contained a range of documentation including lesson plans, a training matrix and details of staff undertaking national vocational qualifications(NVQs)

Staff competency and understanding was not assessed regularly to ensure they had the right skills and competency and that the training was effective. We observed staff struggling to move people safely and they did not have the skills to put individuals into the optimum position to promote independence. They did not always fit moving and handling slings correctly which could place individuals at risk of discomfort and injury. We observed staff assisting people incorrectly with their frames. We concluded that the training and development provided may be sufficient in some areas but it was not consistently demonstrated by staff in the areas of moving and handling and medication. Staff did not recognise some of the practice that we observed as poor.

The provider informed us that training was provided on a range of subjects including dementia, stoma care and diabetes. People were at various stages of their dementia condition ranging from early onset to more advanced stages. Staff told us that they had received a basic level of training in dementia; they said that they would like, and needed, further training to enable them to support people more effectively by understanding how the condition progressed.

Induction for new staff to the service was not thorough and this meant that people may be cared for by staff who do not have the skills and knowledge to meet their needs effectively. Systems were in place for the induction of new staff but these were not followed through and the provider's one week, six week or 12 week induction assessment was not always completed for new staff in relation to the time they had been employed to see how they were progressing.

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

CQC is required by law to monitor the operation of the Deprivation of liberty (DoLS) and The Mental Capacity Act (MCA) which provide legal safeguards for people who may be unable to make decisions about their care. Staff spoken with could not clearly describe what a mental capacity assessment for people meant and why it was required. The records and care plans in place further demonstrated that staff did not have a good understanding of the legislation or their responsibilities. We saw conflicting information about whether individuals had capacity and how decisions were reached and found that some people had bed rails in use on their beds but there was no evidence of best interest decisions regarding this type of restrictive equipment.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not always supported to maintain good health as risks were not well managed. Records of visits from GP and other healthcare professionals evidenced that people had access to health care. However we did not always see that care records were revised to show changes to care and support provision when people's needs had changed.

We were not confident that staff understood the medical conditions of some of the individuals living in the service and how best to support them. One individual had a diagnosis of epilepsy and we saw that they had a risk assessment in place however the type of epilepsy was not clear and there was no guidance as to what staff should look out for and how they should respond if the individual became unwell. Similarly they were caring for individuals who had diabetes one individual was identified on their medication administration chart as being at high risk of hypoglycaemia however there was no guidance for staff as to what they should look out for. Their care plan stated that the district nurse would take blood sugar levels but we could not see that this was happening.

We saw that staff completed a Norton Risk Assessment for each person which is a tool used to identify the risk of developing pressure ulcers. Staff were aware of who was at risk and told us that they were repositioned on a regular

Is the service effective?

basis. People had specialist mattresses and cushions in place and when people were moved we saw that staff moved their cushion to ensure that they continued to receive pressure relief. However we saw one individual who was identified at being at risk lying on their bed on top of a pile of blanket and tangled sheets. We were concerned that they were not receiving the correct pressure relief. Risk assessments had been completed but these were not clear about how often people should be repositioned and the setting of the mattress. The manager told us that information about the mattress settings was recorded in an alternative document.

This is a breach of regulation 12 (2) a and b of the Health and Social Care Act 2008 (regulated activities) regulations 2014

People were supported with food and drinks enabling them to maintain a balanced diet. People told us, “The food is nice most of the time” another person said, “I like the food it is always nice”

We observed that people were offered regular drinks and snacks throughout the day. Lunch looked and smelled appetising. We observed staff offering people choices and supporting individuals to eat. Where support was given this was undertaken at an appropriate pace.

The home used the Malnourishment Universal Scoring Tool (MUST) to identify people at risk of not eating and drinking enough. We saw that there was some confusion among staff about the tool and how it should be used as a number of the scores were incorrect. This meant that there was a risk that staff may not pick up when individuals were losing weight and fail to take action. However we did see that referrals had been made to the dietician for two of the individuals who we had found to be losing weight.

Requires improvement

Is the service caring?

Our findings

At the last inspection the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that interactions were not always respectful and people's dignity was not always promoted. At this inspection we found that improvements had been made.

People told us that the staff were caring and they were generally happy with their care. One person said "The staff care and they are kind." Another person said, "I am looked after very well." There had been a significant number of new staff over the last few months and this meant that not all the staff knew people well. Care plans did not always help as information was sometimes contradictory and difficult to find. One person said "I like to have things put where I need them, new staff don't know this and take things for granted."

Our observations of interactions were that they were generally caring and compassionate. People were spoken to in a kind and patient way and staff took their time to explain to people what they were doing and why.

People's involvement in their own care including planning and making decisions was inconsistent across the service. People who were able were actively involved in making decisions about their care and supported to express their views. One person told us "I can get up when I want to in the morning and go to bed when I want to." However people who experienced difficulty in making decisions and expressing their choice or preference were not always supported properly by some staff and information was not given to them in a way that they understood .For example we were told that the service operated picture menus to help people with choosing of meals. However we observed that staff did not use these and people were woken up and asked what they would like to eat the following day. As a result people were not always able to make an informed choice.

The principles of dignity and independence were not always well understood or consistently promoted. We saw some good practice such as at mealtimes but also poor practice at other points in the day. For example a lack of understanding about moving and handling meant that people were not supported to be as independent as they could be. We saw and were told by staff that they used shared underwear, which does not promote peoples dignity.

People's preferences and choices for their end of life care were not clearly recorded, communicated and kept under review. Preferred Priorities of Care (PPC), end of life directives were not fully completed for those people nearing the end of their life. They showed that choice of place of care or death had been made but they lacked detail to guide staff in relation to planning and delivery for end of life care such as how they wished to be cared for, as well as family/carer involvement.

Requires improvement

Is the service responsive?

Our findings

At our previous inspection in April 2015 we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We were concerned that care plans and records were not clear and as a result people were at risk of receiving poor care.

At this inspection some people spoke positively about the support they received, one person said, "The staff help me to get dressed and to have a bath they know what help I need." Another person said, "The staff are all really nice I have a bath once a week that is enough for me, I only have female staff to help me I wouldn't want a man to help." However not everyone was positive, one person said, "New staff don't know my needs." Our observations were that care was not always consistent or provided in line with peoples preferences.

We found that efforts had been made to update the care records and an index had been put into place. However care plans remained difficult to follow; there was a lot of information but it was not always relevant and key information was omitted. For example we were told that one person had an allergy but when we looked in their records this was not recorded. Further a care plan for an individual with a right sided weakness from a stroke did not inform staff on how to support them in relation to the weak side of their body such as positioning and comfort. There was no information in relation to possible side effects of blood thinning medication and signs and symptoms to be aware of such as bleeding and bruising.

These omissions in care planning were compounded by the fact that there was a number of new staff who did not always know people or their preferences well. We observed an individual being supported with personal care by a male member of staff although there care plan clearly stated that they preferred female care staff. We observed another individual being supported to eat on their side, we asked the member of staff why they were not being assisted to sit up and eat and were told that they were unable to lie on their back, we later observed the individual lying on their back .We looked at this persons care plan and it stated that the individual should "sit upright "when being assisted to eat. We observed two staff assisting an individual to mobilise; they were not confident and did know the individual well. The relative intervened and advised them to how to best support their relative to mobilise.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Handover meetings took place at the beginning of each shift to ensure that staff were aware of recent changes in people's needs. We observed this process as part of the inspection and found the meeting to be informative.

Since the last inspection more formal activities had been introduced and people were positive about their introduction. One person told us, "I have enough to do I read the papers they buy and they have other things going on most of the time." The activities coordinator worked three days a week and then left a programme for staff to follow on the remaining days. We saw an activities folder where staff recorded if individuals had taken part in an activity or if they had refused. The activities provided included singing, ball-games, Christmas decoration making, nail painting and skittles. We observed the activity co-ordinator undertaking crafts with an individual but the majority of individuals were asleep and did not participate.

People told us that they knew how to complain and we saw that there was a complaints procedure in place. The manager told us that no complaints of a formal nature had been received since the last inspection although some concerns such as loss of clothing had been raised but were generally sorted there and then and not raised as a formal complaint.

The manager showed us a new log sheet which has recently been introduced which would clearly show how the process was being implemented and the outcome of the investigation.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in April 2015 we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Audits were not effective and the systems in place to ensure quality were not robust. At this inspection we found a continued breach of regulation for although there had been some improvements there continued to be shortfalls in care practice and there was not always evidence of learning.

The CQC inspection rating previously given to the service was on display in the entrance hall of the home together with a letter from the provider stating that the inspection was disappointing but an action plan was in place to address improvements and raise the standard of care. In response to the report the provider had given a copy of this action plan to the Commission, this plan included a detailed response to the concerns and what actions they were taking and by when. According to the action plan the work needed to address the concerns should have been completed. However, we found an inconsistent picture. Progress had been made in some areas but in others actions had not been fully addressed or improvements made within the timescales: For example, the plan stated that "staff will be involved and included in putting together a set of vision and values for the home", we were told that this had not been undertaken and corresponded with some of our findings which was that staff did not always recognise poor practice. We found anomalies between what was written in the action plan and our findings, for example the action plan stated that specific moving and handling equipment would be outlined in the individuals care plans however this had not been undertaken in all the files that we looked at. There were further gaps around training in the care of people with dementia, competency assessments and specific care plans for individuals with health related needs. A number of changes had been partly implemented but not followed through. For example picture menus had been developed but staff were not consistently using them. We could not be certain that the quality assurance system in place was effective or robust, as the action plan had not addressed the concerns previously identified.

We were told that the provider visited weekly to check on progress and we saw that some audits undertaken such as on infection control and medication. We expressed concern that audits we saw did not identify issues that we identified. In terms of infection control the medication room floor was sticky, the sink used for washing hands and medicine pots was very dirty and corroded; the plug hole contained a build-up of a mouldy looking substance and had not been cleaned for some time. We also found equipment which was not clean such as stand aids, as they had dirt and debris on their bases. We were told that the medication audits were undertaken by the staff who administered medication; they had not identified their practice as problematic. At the last inspection we identified concerns with medication; We noted that the provider had more recently investigated further concerns about lack of pain relief and an action plan was developed to ensure that the concerns would be addressed. However we found continued problems at this inspection and were concerned that learning had not taken place.

We found that the oversight of risk to people in general were not looked at or managed in a proactive way. The care team did not collect information on incidents such as skin tears, infections and pressure ulcers. Data was collected on falls but the manager had not seen this and we could not see that this information was used and analysed for the benefit of individuals. Our observations were that staff were not always clear as to why they were collecting and recording information and therefore it was not used to question or improve practice

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

A new manager had been appointed since our last inspection and had been in post since 01 September 2015. They confirmed that they had submitted their application to register with the Commission. We saw that the manager was being supported by an independent consultant and a manager from another home. Staff were generally positive about the changes and told us that the new manager was open and approachable. One member of staff said, the manager is "Really supportive, has some great ideas, things have really improved." Another member of staff said, "Staff morale is good now and people will cover sickness."

We saw that resident and relative meetings had been held and people had been asked for their suggestions and comments. Information received from the meetings and proposed actions in response were recorded in the minutes and displayed for people to see. A suggestion/comment

Inadequate

Is the service well-led?

box had also been set up in the entrance hall of the service to capture people's views, comments and suggestions. We were told that questionnaires had been sent out to capture resident views and experiences however we saw that these had not been sought since July 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that medicines were not safely managed and the registered person did not always ensure that people received their medication as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to people and their health and safety were not fully assessed and the registered person was not doing all that was reasonably practicable to mitigate the risks

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not ensured that staff received suitable training, professional development and supervision that is necessary to enable them to appropriately perform the duties required of their role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person did not yet have an effective system or process to assess and monitor the quality of the service and manage risks.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014. We found that staff did not understand their responsibilities under the Mental Capacity Act regarding consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that staff were not suitably deployed and people did not have their needs met promptly

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the care delivered did not always meet peoples needs or preferences