Four Seasons (Evedale) Limited

The Gables

Inspection report

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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

Our inspection was unannounced and took place on 25 and 27 April 2016.

At our last inspection in April 2014 the provider was meeting all of the regulations that we assessed.

The provider is registered to accommodate and deliver nursing and personal care to a maximum of 51 people. At the time of our inspection 46 people lived at the home. People were elderly and lived with needs associated with various health conditions, physical disability, or general frailty.

The Gables premises had two different floors where people lived and spent their time. Each floor had its own dining room and lounges. All bedrooms were single occupancy.

There was a management team that people and relatives could access if they had the need. The manager and provider had some systems to monitor the service. However, the overall governance and leadership of the home was ineffective and placed people at a risk of not having their needs met.

The manager was not registered with us as is required by law. However, they had started the process to register with us to address this. A registered manager is a person who is 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.

Prior to the inspection we were made aware of concerns that had been identified by the local Clinical Commissioning Group and Local Authority both of whom commission care on behalf of some people who lived at the home. We found that cleanliness of the home was not adequate and attention had not always taken to address this. We also found that the premises had not been maintained to a good standard. We identified that there were not always enough staff available to meet people's needs, or that at times staff had not been suitably deployed to meet needs in a timely manner.

We found that medicine management systems needed some improvement so that people would consistently receive their medicine safely and as it had been prescribed by their doctor.

We found that staff did not always follow instructions to ensure that people were not placed at potential risk of experiencing sore skin.

Some people who lived at the home described the staff as being nice and kind, however other people told us that this was not always the case.

We observed that some staff did not follow basic principles to ensure that people's dignity was maintained. Relatives felt that the staff were polite and showed their family member respect.

Activity provision was not always tailored to meet people's individual needs and aspirations.

Records made by staff did not confirm that the support they provided was personalised to the individual.

People told us that they enjoyed the meals provided. However, staff did not always give the support people needed to eat and drink.

Staff had received training about safeguarding the people in their care to prevent them from being placed at risk of abuse or bad treatment. However, staff had not received other core areas of training that was required and did not all receive supervision sessions regularly.

Processes were in place to induct new staff to ensure that they had some knowledge when they first started work.

Staff had understanding and knowledge regarding the Mental Capacity Act and the Deprivation of Liberty Safeguarding (DoLS). This ensured that people who used the service were not unlawfully restricted.

A complaints procedure was accessible for people and relatives to use if they felt they had the need.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always given safely and records maintain did not always confirm that people were being given their medicines as they had been prescribed.

Insufficient action had been taken to ensure the cleanliness of the premises.

Staff did not follow instructions to manage the risk of people developing sore skin.

People felt that staffing levels and the way staff were deployed did not always meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received the training that was required.

Staff felt that they were supported but did not always receive regular supervision sessions.

Some people and their relatives felt that the service provided was reasonable.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although people described most staff as being kind and caring some people said that they were not.

People's basic dignity needs were not always ensured by staff.

People's privacy and independence were promoted and maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people felt that activity provision was not tailored to meet their individual needs and aspirations.

The majority of people and their relatives confirmed that the staff knew the people well enough to meet their needs.

Complaints processes were in place for people and relatives to raise concerns if they had the need.

Is the service well-led?

Requires Improvement

The service was not well-led.

The provider had not ensured effective leadership.

The provider had not taken sufficient action to ensure that the service was operating as it should. Audits and action plans had not been effective to identify areas that required improvement at the pace required.

The service provided did not always ensure that people would receive safe and appropriate care.

The Gables

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.

Our inspection was unannounced and took place over two days; 25 and 27 April 2016. Our inspection team included 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 asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information is then used to help us plan our inspection. The form was completed and returned so we were able to take information into account when we planned our inspection. We asked the local authority their views on the service provided. We also reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as 'notifications'. We looked at the notifications the provider had sent to us. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We spoke with six care staff, two nurses, a cleaner, the cook, the activities co-ordinator, the manager and a support manager who was assisting the manager. We spoke with and engaged with 12 people who lived at the home and four relatives. We looked at five people's care records, five people's medicine records, accident records and the systems the provider had in place to monitor the quality and safety of the service provided. We also looked at three staff recruitment records and the staff training matrix. We observed in communal areas to see how the care and support was provided and the mealtime experience. We also looked at some provider feedback forms that had recently been completed by the people who lived at the home and their relatives or friends.

Requires Improvement

Is the service safe?

Our findings

A person said, "The staff keep my room nice and clean". Provider feedback forms that we looked at completed by three people confirmed that they felt that their bedrooms were cleaned to a high standard, "Most of the time". Prior to our inspection the Clinical Commissioning Group (CCG) who fund some placements at the home told us that there had been concerns raised with the provider regarding the cleanliness of the premises. The provider had produced an action plan for improvements to be made and was working to this. However, we found that even the basic cleanliness of the home still required improvement. We saw that there was dried food on dining chairs in the ground floor dining room that had been there for some time. We observed the breakfast time that day and saw that no person used the chairs that morning indicating that the dried food debris was at least from the previous day. We saw that there was dried fluid on at least two bedroom walls. In some toilet rooms we noted that there were no waste bins for people to discard used paper towels after drying their hands. We also saw that the sealant around sinks in some bathrooms, toilets and the treatment room was damaged so could have been a place for bacteria to grow. This showed that the cleanliness and hygiene standards needed to be improved to prevent people being at risk of acquiring an infection. The manager told us that a new staff member [who would be starting at the home within the next month] would be nominated the lead for overseeing infection prevention. The manager told us that new cleaning schedules had been introduced that week with the intention of improving cleanliness and this was confirmed by the cleaning staff we spoke with.

We saw that décor in many places needed attention as wall, door, and skirting boards were scratched and damaged. We saw that ceiling tiles in corridors were badly stained and that there was a build-up of dust around radiators and pipework particularly in corridor areas. This showed that people had not been provided with premises that were maintained to a satisfactory standard.

The provider's on-going assessment of the service had failed to identify the issues we found in respect of the cleanliness and decorative standard of the premises.

The medicine administration system in place was not always safe and records maintained of what the medicine people had received did not always confirm that people were being given their medicines as they had been prescribed.

We found that where medicine had been prescribed as a variable dose, for instance where one or two tablets could be given, the number given was not always recorded. We saw that there were protocols in place to advise staff when such medicine should be given. This would ensure that people were given their medicines when they were needed and not given when they were not. For one person their medicine records did not confirm that they had been given their medicine as it had been prescribed. We found that there were a higher number of tablets remaining than there should have been if they had been given correctly. For another person medicine records did not highlight that their skin cream had been applied at the intervals required by the doctor. For another person there was no audit trail to confirm if they should still be administered one of their prescribed tablets. There were no tablets available and no record to confirm if the tablets had been discontinued by their GP. We saw two medicine records that lacked a staff signature to

confirm the administration of the person's medicine, or a reason documented to explain, why the medicine record had not been signed.

We found that where medicines were prescribed as a short course, this included antibiotics, there were no guidance in place to instruct staff how the medicines should be given, or if they should be aware of any possible side effects to prevent people experiencing ill health. However, once we raised this with the manager they put short term care plans in place for staff to follow and improve medicine administration.

A person who lived at the home told us that, "My medicines are mostly given on time". Other people told us that they preferred that staff manage their medicines rather than them managing them independently. One person said, "I am glad staff look after them [the medicines] for me". We observed a nurse giving people their medicines. We saw that they explained what they were doing. Ensured that they had a drink to take their medicines and stayed with people to make sure that they had taken their medicines.

We saw that medicines were securely stored. In line with good practice expectations we saw that where medicine records were handwritten there were two staff signatures to confirm that what had been written was correct to prevent errors.

Although the manager took action to address the issues noted about medicine management, the systems in place to assess and monitor safe handling of medicine failed to identify the issues we found.

We found that people who had known risks of developing pressure sores had a risk assessment in place. The risk assessments provided staff with guidance on how people needed to be moved by staff to prevent skin damage, however information received from people and records maintained by staff indicated that that people did not receive support inline with their agreed plan of care. People were being placed at risk of developing sore skin.

Other risks to people had been identified and management plans had been put in place to protect people and keep them safe. Two people told us that they had reported a risk to the manager who had ensured that action was taken to protect them. People and relatives we spoke with told that they had not experienced or witnessed any abuse. A person said, "No, nothing like that". Another person told us, "The staff are not like that". Staff we spoke with told us that they had received training in how to safeguard people from abuse and knew how to recognise the signs of abuse and how to report their concerns. A staff member told us, "If I am concerned about anything I report to my manager". The manager had reported to the relevant agencies any issues of concern as they should to prevent people being placed at risk of harm.

People had mixed views about staffing levels and the deployment of staff. Some people told us that there were enough staff. A person said, "I think there are enough staff. They are available when I need them". Other people felt differently telling us that there were insufficient staff to meet their needs particularly at weekends. One person said, "Sometimes we have to wait too long". Another person said, "I think there should be more staff on. The buzzer [call system] can take half an hour to be answered". Staff we spoke with also had mixed views about staffing levels. One staff member told us, "In general there are enough staff. It is when staff phone in sick that problems can occur". Another staff member said, "We could do with more staff". On occasions we heard that the call system was sounding for a few minutes. During the morning for a period of ten minutes one lounge was unattended by staff. At other times during the day we saw that there were adequate numbers of staff available. At meals times we saw that there were staff available to serve the food and give people the assistance they needed.

The manager told us that they had a dependency tool to assess the staffing numbers needed and that they

would continue to use this. However, there was no assurance that doing so would ensure that people would receive prompt attention. They told us that they would continue to monitor staffing levels and make observations to ensure that staff were suitably deployed. The manager told us that there had been some staffing problems as a number of nurses and staff had left at the same time. Some new nurses and staff had started work, however, at this time it could not be evidenced that the new staff were having a positive impact upon people's care. Records highlighted and the manager told us that they had also recruited some additional new staff who would commence work within in next few weeks. The manager also told us that they had recruited a new deputy manager. Staff told us that they covered each other for leave and in general that worked.

A person told us, "I am unsteady on my feet. The staff have been marvellous". The manager told us how they monitored incidents, falls and accidents. We had not been made aware of any concerns regarding unavoidable, or a high number of falls. We saw that aids to support people when they were mobilising were available. We saw that staff supported people to walk safely and assisted them when they needed to be moved from chair to chair. We saw from records, which were confirmed by staff, that referrals had been made to occupational therapy and physiotherapy for advice and guidance on how to prevent people from falling.

Safe recruitment systems were in place. Staff confirmed that checks had been undertaken before they were allowed to start work. A staff member told us, "I had all the checks done before I was allowed to work". The manager said, "No staff can start work until all of their checks have been completed". We checked three staff recruitment records and saw that pre-employment checks had been carried out. These included the obtaining of references and checks with the Disclosure and Barring Service (DBS). The DBS check would show if a prospective staff member had a criminal record or had been barred from working with adults due to abuse or other concerns. These checks minimised the risk of unsuitable staff being employed. We also saw that checks for nursing staff were undertaken with the Nursing and Midwifery Council (NMC), which confirmed that the nurses were eligible and safe to practice.

Requires Improvement

Is the service effective?

Our findings

Some people and relatives told us that the service provided was good. One person said, "I think it is good so far. I have not been here long". Another person said, "There are some things that could be better but overall it is fairly good". A relative said, "My other relative was in another care home. It was not as good and as nice as it is here". Other people told us that improvements could be made.

A staff member told us, "I had induction training when I started. I went through policies and procedures and introduction to people". Another staff member was complimentary about their induction training and told us that they had 'shadowing' shifts with experienced staff to be introduced to the people who lived there and to get familiar with the way in which they should work. Staff files that we looked at held documentary evidence to demonstrate that induction processes were in place. The manager told us that new staff were working with the new 'Care Certificate'. A new staff member confirmed that this was correct. The Care Certificate is an identified set of standards that care staff should follow when carrying out their work.

A staff member said, "I am supported when I need advice". Other staff we spoke with told us that they also felt supported on a day to day basis. Staff told us that they had received some supervision. However, records highlighted and the manager told us that not all staff had received regular supervision. The manager told us that when the new deputy manager started work the staff supervisions would get up to date. The manager told us and records confirmed that where there were issues with staff performance this was monitored for improvements to be made.

A person said, "I am looked after well". A relative said, "The staff know what they need to do." A staff member said, "I have done some training". Another staff member told us, "I feel confident and safe to do my job". The training matrix and staff files we looked at confirmed that some staff had received training that the provider had determined was mandatory and some specialist training for their role. However, this was not the case for all staff. The manager agreed that staff training was an area that needed attention. They told us that so many new staff had started over the last few months that it had been difficult to provide them with all with training. They assured us that the training was being arranged.

A person said, "The staff give me drinks all day". Throughout the day we saw staff offered people drinks regularly. However, we observed that staff did not always support and encourage people who needed support to be able to drink what they had chosen. We noted that this was a particular issue for people who were cared for in bed. We saw that full cups of cold tea were next to two people. The manager told us that this should not happen and advised that staff had been instructed to ensure that all people are encouraged to drink. This meant that there was a potential risk that those people could experience dehydration.

We observed that one person was not supported to eat until we had highlighted to staff that the person needed assistance. A relative told us, "I think that the encouraging of people to eat could be improved upon". We saw that staff were available to give people assistance with eating and drinking and when this was done we saw that this was done in an unhurried way.

People told us, "I like the food. I have a choice and can have as much as I want. I cannot fault it", "The food is lovely" and "I am very picky and choosy where food is concerned. The cook came to talk to me about what food I would like". We looked at two people's care plans and saw that their food and drink likes and dislikes had been asked about and recorded. Care staff and the cook had a good knowledge of people's food and drink likes and dislikes. The cook also had a good knowledge of people's medical dietary needs and how these should be catered for that included diabetic and gluten free diets.

We observed the breakfast and midday mealtimes. Food options were available at each meal. At breakfast time people could chose cereals and toast or a full cooked breakfast. At lunch time there was at least two hot meal options available. We saw that one person did not like their meal. Staff asked them if they would like something else. They asked for soup and that was provided and the person consumed it. Another person told us, "It does not matter what staff offer I only like to eat a few things. That is my choice and I get the things I like".

A person told us, "I am weighed every month". Records highlighted that people were weighed on a monthly basis. The cook told us that if people were at risk of weight loss, or had lost weight, they could add calories to their meals by using butter, full fat milk and cream. Where there were concerns records showed that people were referred to a dietician and staff we spoke with confirmed this. When people had difficulty swallowing staff had referred them to speech and language specialists. We saw that some people needed a thickening agent in their drinks to prevent choking. Staff we asked knew which people needed these products and we saw that the products were used.

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 said, "I do what I want to". Another person told us, "There are no limits". We checked if the staff were working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that assessments were undertaken where appropriate to determine people's level of capacity. Where people did not have capacity the manager told us and records that we looked at confirmed that where appropriate a number of DoLS applications had been made and had been approved by the local authority. Staff we spoke with knew which people the DoLS approvals related to and the reasons for the approvals. We identified from training records that some staff had received MCA and DoLS training but not all. However, staff we spoke with were aware of MCA and DoLS. They had a knowledge of, and gave us an account of, the principles of the MCA and DoLS. Staff knew that people should not be unlawfully restricted.

A person said, "The staff always ask me first". Staff we spoke with told us that they asked people's permission before they provided care and support. We heard staff asking people if they could help and support them before they carried out any support or care. Staff we spoke with understood the importance of asking people's permission before they provided support. A staff member said, "I explain and ask people before I provide support". We heard staff explaining to a person why they should move from their wheelchair into an easy chair (to make them more comfortable). We saw that person respond by saying "Yes", and co-operated happily with staff for the task to be undertaken. However, at mealtimes we observed that some staff put clothes protectors on people without asking them first which contradicted what staff had told us.

A relative told us, "There is no delay when they [their family member] need a doctor. They have not been well but are looking a lot better today". A person said, "The staff get the doctor if I am not well". Another person said, "I have my eyes tested and my feet done". Other people and relatives we spoke with confirmed that staff generally supported people to access routine health or social care services. Staff told us and records confirmed that people who required healthcare support were seen by specialist health care staff when there was a need to ensure that their health needs were met.

Requires Improvement

Is the service caring?

Our findings

We observed on two occasions that staff did not ensure that people were covered when they hoisted them. We saw that people's under clothes were visible to other people whilst they were being assisted. This meant that staff did not take care to ensure that people's basic dignity needs were met.

Some people we spoke with told us that the staff were mostly polite. However, at least two people told us that this was not the case. People told us that some staff were caring but their experiences were not consistent. A person said, "The staff are kind but some are better than others. One staff did not speak to me nicely". Another person said, "The staff are very kind except one. I do not like their attitude". A third person told us, "The staff are mostly caring". A relative told us, "The staff are kind. They always try to make sure that she [person's name] is alright". We heard a person asking a staff member to buy them some muffins for them on the way to work. The staff member agreed willingly to do this. A staff member told us, "I think all the staff here are all very caring".

We observed that staff promoted people's confidentiality by securing their personal records in locked cupboards. We saw the provider's confidentiality policy. Staff we spoke with told us that they read this when they started to work at the home. A staff member told us, "All the staff know that we should not discuss anything about the people here outside of work, to other people who live here, or to other relatives".

We observed some interactions between staff and the people who lived there and saw staff chatted with people in a friendly, caring way. Early morning we saw staff approach each person in a friendly way, they said good morning, asked how they were, asked about their family and showed a genuine interest in them. We observed that two people became agitated but staff were quick to kindly and gently reassure them to divert their attention. We saw that the people responded to this and became calm.

A person said, "I do things for myself when I can". People we spoke with told us that staff encouraged them to be independent. Staff we spoke with all told us that they only supported people do things that they could not do. We observed staff encouraging people to walk rather than them be pushed in wheelchairs with the aim of helping them to retain their mobility and independence. We heard staff encouraging people to eat and drink independently. We saw that specialist cups were available to assist people to drink independently.

A person said, "I like to look well presented". People told us that they selected their own clothes to wear each day. We saw that people wore clothing that was suitable for the weather and reflected their individuality. A person said, "I tell staff what I want to wear". Another person told us, "I choose my own clothes, I like to look nice". Care records that we looked at highlighted that people's appearance was important to them. A relative said, "The hairdresser comes regularly and they [person's name] like having their hair done". Staff we spoke with were aware of people's wishes regarding their appearance and confirmed that they gave support to meet people's appearance and associated needs.

People we spoke with all enjoyed having visits from their family and the provider ensured flexible visiting to accommodate this. One person said, "I like it when my family come. They can come any time". Relatives told

us that they could visit without any restrictions. A relative said, "I visit when I want to and am made to feel welcome by staff".

People confirmed that staff communicated with them in a way that they understood. A person said, "The staff talk to me in a way I understand". We saw that staff spoke with people in a calm way. They made sure that they faced people when they spoke with them. They waited to make sure that people had understood what was said to them and repeated what they said if they thought they had not. This demonstrated that staff knew it was important to communicate with people in a way they understood.

We saw that information was displayed giving contact details for independent advocate services. An advocate can be used when people may have difficulty making decisions and require this support to voice their views and wishes. The manager and staff told us that people would be assisted to access an advocate if they required it to help them make decisions about their care and support.

Requires Improvement

Is the service responsive?

Our findings

A person told us, "There are a lot of things for us to do". Another person said, "It is good we can do lots of things. I like bingo best". A third person said, "I think there could be more. Sometimes it is boring here". The activities co-ordinator told us about the singers and other entertainers who visited the home. We heard them talking to people about forthcoming events and anything different they would like to do. The activities co-ordinator showed us photos that had been taken when a buffet had recently taken place to celebrate the Queen's birthday. During the morning we saw that a game of bingo took place in the ground floor lounge and people clearly enjoyed this. We heard them chatting and laughing. Some people told us that they did not want to join in group activities they preferred to watch the television or read a book and did this. However, we found that activity provision on the first floor was not so organised. Some people told us that they would like to be offered more activities. One person said, "I would like to go out sometimes". The manager agreed and told us that they were looking to improve this.

We observed that some staff interactions with people ensured personalised care in that they asked people what their preferences were. However, at other times we found that care was task orientated in that people were got out of bed, taken to the dining room and sat in the lounge without choices being given. We found that records made on a daily basis by staff were very 'task' orientated. They highlighted what had been done for the person rather than confirming that people had chosen how they wanted to be supported each day. The manager told us that they were aware of this and had secured some record keeping training for staff.

A person told us, "Before I came here they asked questions about me". The manager told us and records that we looked at confirmed that prior to people moving into the home an assessment of need was carried out. This was with the person and/or their relative to identify their individual needs, personal preferences and any risks to ensure that their needs could be met.

A person said, "The staff know me well and what I need". A relative told us, "I think they [the staff] know her [person's name] and meet her needs". Care records that we looked at contained some important things about each person including their family members, where they lived previously, what they liked and did not like and how they best communicated. We read this information and asked staff about individual people. Staff we spoke with had knowledge of what was written about individual people. A staff member said, "We look at the records and care plans. I think all of the staff know the people we support well". Staff told us that people's care plans were reviewed regularly. Although, people and relatives we asked were not all aware, or could not remember seeing a care plan, they told us that staff involved them in deciding how support would best be provided to make it appropriate.

A person told us, "Someone from my church comes to see me". People we spoke with told us that they were offered the opportunity attend religious services if they wanted to. Religious input had been secured and representatives from a local church went to the home every week. This demonstrated that the provider knew it was important that people had the opportunity to practice their faith if they wished to.

A person told us, "I did a questionnaire with the staff". Other people and relatives also told us that staff

asked them about their care. We saw completed provider feedback forms. The overall feedback did not highlight any concerns and showed that people were reasonably satisfied with the service they received. The provider had another process in place for people and their relatives to make their views known and to make suggestions. Forms were available in the front entrance hall of the home that could be completed and placed in an internal 'post box'. The manager said, "We take comments and suggestions seriously and it helps us to know where we need to change or improve". Meeting minutes that we looked at showed that the manager provided feedback to people and relatives in respect of any action that they had taken. This included the recruitment of new staff.

A person said, "I would tell the staff if I had a complaint". A relative said, "If I needed to I would raise any issues with staff". Another relative told us, "The manager does take heed of complaints". Most people who lived at the home and their relatives told us that they were aware of the complaints procedure. We saw that a complaints procedure was in place and that a copy was also available in the entrance area of the home. We did not see that any recent complaints had been made.

Requires Improvement

Is the service well-led?

Our findings

The provider's audit systems had not always identified shortfalls in the provision of care and support consequently, appropriate actions had always not been taken to make improvements. The Clinical Commissioning Group (CCG) who fund some placements at the home had identified two months prior to our inspection that the cleanliness of the home was not satisfactory. The provider had produced an action plan to address this. However, we found that basic cleanliness of the premises was still not adequate. The systems in place to assess, monitor and manage risks were not effective and failed to identify issues identified during the inspection. Improvements to drive up the quality the quality of the service were not always identified or acted on. We found that staff were not always working as they should to prevent people from being at risk from care that did not meet their needs. The nurses in charge of the shifts had not identified that people had not received their skin care and the manager was not aware of this. We saw that staff did not always ensure that people were given support and encouragement to ensure that they drank enough to prevent a potential risk of dehydration. We identified that medicines were not always given safely and records did not always confirm that people were being given their medicines as they had been prescribed to prevent ill health. Records that we looked were task orientated rather than being personalised. In that they described the care being provided by staff as what they had done task by task, rather than confirming that people had been treated as individuals. This meant that checking processes were not effective to ensure that people received the safe care and support they needed in a clean environment to prevent them being placed at risk of not having their needs met and/or ill health.

This is a breach of Regulation 17(1)(2)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2014.

The manager was not registered with us as is required by law. The manager had applied to register to address this shortfall. A staff member said, "The new manager is good. They have the people here as the most important". A person said, "The new manager is making some changes and improving things". At the time the previous manager left the home a number of nurses and care staff also left which had an impact on the home. The provider had taken action to address this by recruiting new staff. However, the manager told us that there was still a lot of work to do and was aware that improvements were needed. The provider had ensured that the manager had support, by allocating a manager from another home to give input on a weekly basis to start making improvements.

A staff member told us, "I feel supported by the managers. I am happy working here". We looked at a selection of staff meeting minutes and found that the meetings were held regularly. We found that on-call arrangements were in place so that staff could access help and advice when the manager was off duty.

A person said, "Yes I know the manager. They come and speak with me they are nice". Some people and relatives told us that they did not know who the new manager was. However, we saw that the manager was visible within the home. We observed that people smiled and engaged with the manager which showed that they were familiar with her. We saw meeting minutes and the manager confirmed that people and relatives had been invited to meetings so that they had the opportunity to raise issues and or any concerns that they may have. The meeting minutes highlighted that the manager was trying to keep people informed about the

staffing issues and improvements that they were trying to make.

The provider met their legal requirements and notified us about events that they were required to by law. They had informed us about Deprivation of Liberty Safeguarding (DoLS) approvals that had been made and any issues of concern.

The staff we spoke with gave us a good account of what they would do if they were worried by anything or witnessed bad practice. One staff member said, "If I saw anything I was concerned about I would report it to the manager. We have policies and procedures regarding whistle blowing". We saw that a whistle blowing procedure was in place for staff to follow.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2014. The provider did not have an effective system in place to regularly assess and monitor the quality of service that people received. The provider did not monitor and mitigate the risks relating to the health, safety and welfare of people.