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The Manor Care Homes

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

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

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

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

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

Summary of findings

inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The Manor Care Homes provides nursing and residential care for up to 67 people many of whom are living with dementia. At the time of our inspection there were 43 people in residence. Accommodation is divided into three units, referred to as Sovereign, Tudor and Windsor. Each unit has designated communal areas and bedroom facilities. Accommodation for Tudor and Windsor units is provided over two floors with access via a passenger lift. There is a garden which is accessible and provides areas of interest.

This inspection took place on 3 November 2015 and was unannounced. We returned on 4 November 2015.

The Manor Care Homes had a registered manager in post at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection of the 14 July 2014 we asked the provider to take action. We asked them to make improvements with regards to medicines. We received an action plan from the provider which outlined the action they were going to take. We found that the provider had made some improvements.

However we found the policy and procedure for the safe handling of medicine was not being followed. The system for recording medicine in and out of the service was not robust which had the potential to compromise the safety of people using the service. We found people's plans of care did not contain sufficient guidance for staff to ensure people received their medicine in a safe and consistent manner. Nurses responsible for the administration of medicine had not had their competency assessed.

People were supported by staff that had received training and had an understanding as to their role and responsibilities in reporting concerns with regards to abuse. Posters were displayed throughout the service which provided information as to external agencies to which concerns about abuse could be reported.

People at the point of moving into the service had potential risks to their health, safety and welfare assessed. People's plans of care provided information as to how potential risks to people were to be minimised, however in some instances the information was not consistent and the process and information used to review people's needs was not clear.

We found instances where people's safety was compromised as the deployment of staff was not managed well. We found staff in some instances providing care and support to people who had not received the training to enable them to care for people safely.

We found systems and equipment were mostly maintained to a good standard. However within two units the environment was not maintained sufficiently to keep people safe. The provider had a plan for the closure of Tudor unit to facilitate its refurbishment.

People were supported by staff whose induction was not robust as records about staff induction were not consistently completed. Our observations showed that staff recently employed by the service were not effectively supervised. Staff did not receive regular supervision or have their competency assessed or appraised, which meant people did not always receive effective care. We found that the deployment of staff around the service was not effectively managed which meant the quality and consistency of care people received was mixed.

The use of agency staff meant that not all staff were familiar with the needs of people and their safety and well-being was compromised as people's records did not always contain up to date and accurate information as to their needs. We found some staff to have a good understanding of the needs of people. People we spoke with and their relatives in the main told us they were happy with the care they received from staff.

People's records showed that their capacity to make informed decisions had not always been considered and documented. We found people's relatives in some

Summary of findings

instances had been asked to given consent to aspects of people's care, which was not always reflective of the Mental Capacity Act 2005. The provider in conjunction with the consultancy firm was in the process of reviewing people's plans of care so they reflected people's capacity to make informed decisions.

People's records showed that health care professionals had been involved where a person's dietary intake was a cause for concern. Specialist diets, which included 'soft' diets for people who were at risk of choking, were provided. People's nutritional intake was recorded to ensure people ate sufficiently.

We observed that people's dining experience was mixed; the factor which contributed to this was the deployment and knowledge of staff to be able to assist people with their meals in a timely and sensitive manner. During the inspection we brought to the attention of the deputy manager and representative of the consultancy firm our concerns during and after the lunchtime meal in one unit as people were not receiving support in a timely manner. We observed some people were supported to eat their meal by staff that had a good understanding as to people's needs and who encouraged people to eat in a caring and sensitive manner.

People and their visitors in the main spoke positively about the care people received from staff. We observed staff spending time with people in conversation and activities; however our observations showed inconsistencies over both days of our inspection or with regards to the individual units. In some instances we found people were not encouraged to take part in meaningful activities and staff did not spend time talking with people.

People's involvement and that of their relatives in the development and reviewing of their care needs was not consistent. Records in some instances detailed the involvement of people's relatives which was confirmed by visitors we spoke with. However in some instances we found people's involvement or that of their relatives was not documented. Others records did not reflect what were important to individuals, such as their preferred daily routine or information as to their likes and dislikes. This meant that people's support and care provided by staff was often driven by their need to complete tasks to ensure the running of the service rather that reflective of the individual needs of people.

People were aware of how to raise a concern and were confident to do so. Records showed that complaints were recorded and investigated, however records did not in all instances identify the outcome of the complaint investigation and how this information had been shared with the complainant.

The provider did not have quality assurance and governance systems in order to effectively monitor the quality and safety of the service provided. There was no evidence of audits being undertaken to be used as lessons learnt, with regards to risk, incidents, accidents and complaints that would support the provider and staff to reduce the likelihood of events reoccurring and therefore improve care.

A limited number of recent audits had been undertaken by the deputy manager had been carried out, however shortfalls identified had not been acted upon.

We found that policies and procedures with regards to quality monitoring, the management of complaints and safe administration of medicine were not followed. This had a direct impact on the quality of care people received.

The provider did not have an overview as to the care people received and therefore could not commit resources and develop the service.

Local authorities for health and social care who fund people's packages of care have identified concerns as to the service being provided at The Manor Care Homes. Representatives from these authorities have been visiting the service in order to look into specific concerns.

The provider having received feedback from funding authorities has entered into a contract with a consultancy firm to provide support and guidance to bring about improvements to the service. The provider and representatives of the consultancy firm were at the service during our inspection.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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?

Requires improvement

The service is not consistently safe.

People told us they felt safe. Staff we spoke with were aware as to their role and responsibilities in keeping people safe from abuse and had information as to who they were to contact should they suspect abuse.

Risks to people's safety were not consistently addressed as staff responsible for people's care were not appropriately deployed, or given sufficient guidance and instruction.

People's safety was not always maintained or promoted as they were not always sufficiently knowledgeable and experienced staff to meet people's needs safely.

People received their medicines from nursing staff. However people's competency to administer medicine was not assessed. Policies and procedures to ensure safe practices in relation to medicine management were not followed.

Is the service effective?

Requires improvement

The service is not consistently effective.

Staff were not sufficiently inducted, trained or supervised to ensure the care they provided was effective and reflected good practice.

Staff had an understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005; however people's capacity to make informed decisions were not consistently documented within their records and kept under review.

People were supported to eat and drink enough to maintain a balanced diet. The dining experience of people and the support they received was not always managed well or met their needs.

People were supported to access health care services and receive on-going health care support.

Is the service caring?

Requires improvement

The service is not consistently caring.

People we spoke with were happy with the care and support they received and said that staff had a kind and caring approach.

People and their relatives were not always involved in the development and reviewing of plans of care.

Summary of findings

People's experience as to the promotion of the privacy and dignity was inconsistent as the deployment, knowledge and experience of staff had not been considered by the management team.

Is the service responsive?

Inadequate

The service is not responsive.

Staff in some instance knew how to support people and took account of people's individual preferences in the delivery of care. People's plans of care were not always up to date or contained consistent information. This impacted on people's care where it was provided by staff that were unfamiliar with people's needs as they did not have access to accurately written documentation.

People and their visitors knew how to raise a concern or make a complaint. We found people's concerns had been documented; however documentation was not consistently completed and did not always show what information had been given to the complainant following the investigation.

Is the service well-led?

Inadequate

The service is not well-led.

People who used the service and their relatives were not consistently involved in the development of their care or that of the service. People's comments reflected that people in the main were satisfied with the service they received however they did not always feel they were sufficiently consulted.

There was a registered manager in post and the provider regularly visited the service. There was no clear leadership structure within the service which meant the deployment of staff and their roles and responsibilities were unclear, which impacted on the quality of care people received.

The provider did not have quality assurance and governance systems to effectively monitor the quality and safety of the service provided. This had a direct impact on the quality of the care people received.

The Manor Care Homes

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 3 November 2015 and was unannounced. We returned on 4 November 2015.

Local authorities for health and social care who fund people's packages of care had issues of concern raised with them about this service which they shared with the Care Quality Commission (CQC). We reviewed the information along with other information we held about the service which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about.

Before the inspection, 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. The PIR was completed and returned.

The inspection was carried out by four inspectors, a pharmacy inspector, a specialist advisor with a specialist interest in dementia and nursing care, 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. Our expert by experience for this inspection had expertise in the care of older people living with dementia.

We spoke with 21 people who used the service (people in some instances may have been spoken with by more than one person within the inspection team) and five visiting relatives. We spoke with the provider, the deputy manager, two nurses, eight care staff and a visiting health care professional. We looked at the records of 12 people, which included their plans of care, risk assessments and medication records. We also looked at the recruitment files of four members of staff, a range of policies and procedures, maintenance records of equipment and the building, quality assurance audits and the minutes of staff meetings.

We asked the provider to send us information about staff training which was provided.

Requires improvement

Is the service safe?

Our findings

At our inspection of 14 July 2014 we found that there were unsafe arrangements in place in relation to consistent temperature monitoring with regards to the storage of medicines and the recording or topical medicine application. We found the provider was unable to account for the amount of PRN [as required] medicines on site. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements. At this inspection we found that some improvements had been made.

We found medicines were stored securely. There was a record of the temperatures of the areas where medicines were stored which were within the acceptable limits to maintain the quality of medicines used.

People said they received their medicines on time. One person told us that they had paracetamol to manage pain, which they asked for when needed. They said they were always asked if they had wanted any paracetamol and the level of pain they experienced.

A visiting health care professional told us that and when people's medicines changed or new medicines were prescribed staff ensured medicines were received into the service and administered promptly.

We looked at the storage of medicines and the medication records relating to 25 of the 43 people who use the service.

There was a current medicines policy in place but it hadn't been fully implemented and staff were not following the procedures outlined in the policy. The deputy manager told us that they planned to train staff on the policy as part of an overall review of processes.

Medicines were administered by qualified nurses, but the provider had not checked their competency.

Records showed that medicines were administered in line with prescriber's instructions; however we found people did not have a protocol in place which identified the quantity and the reasons for the administration of PRN medicine. We noted that one person's records stated 'administer one or two co-codamol four times per day'. The nurse told us that the person was unable to verbally communicate their pain levels and we found that there were no instructions within the person's plans of care as to how the person expressed they were in pain. The nurse told us "Since she can't communicate their pain level, I will give her two." This meant the person was at risk of not receiving the medicine they required in a consistent manner as records did not provide sufficient guidance and instructions for staff.

Some people were administered medicine covertly, disguised in food or drink. This had been agreed with healthcare professionals and family members and a pharmacist had been consulted when it was necessary to crush tablets. However the plans of care did not include enough detail to ensure that staff gave the medicine in a consistent way, for example in what the medicine was to be disguised in such as food or drink and the need to ensure the medicine was taken.

Medicines administration records did not include a photograph of the person to help nurses confirm the identity of the person before administering their medicines. Nurses told us that they would check with another member of staff if they were unsure.

Records of medicines received, used and disposed of did not provide a full audit trail and did not allow all medicines to be accounted for. There was no record of stock carried over from the last cycle, and when instructed to give one or two tablets, staff did not always record the dose given. This meant people's medicines were not sufficiently monitored which had the potential to impact on well-being.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely with appropriate records, but the process for disposing of waste controlled drugs wasn't clearly set out in the policy, and was not consistently followed on all units.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection within Tudor unit we noted that repairs were being undertaken to the lift. This meant that the external fire door had to be propped open to enable work materials to be delivered. We observed one person who uses the service make their way through the open door to the outside and a member of the maintenance team escorted them back along the corridor.

Requires improvement

Is the service safe?

Staff had not noticed the person go outside which meant the person had been at risk of harm. We brought this to the attention of the deputy manager and consultancy representative who took steps to prevent a reoccurrence.

The provider did not have a system in place that reviewed accidents and incidents within the service to enable them to determine whether policies and procedures required updating to help prevent the reoccurrence of events which had the potential to put people at risk.

We asked the deputy manager how staffing levels were determined and they showed us the tool used to determine staffing levels which was dependent upon the needs of people. However they told us, which records confirmed, that the assessment to determine staffing numbers was last reviewed in July 2015.

Our observations with regards to the suitability and numbers of staff on duty to meet people's needs safely were mixed. In many instances the lack of co-ordination of staff and their awareness of people's needs reflected negatively on the experience of care people received. We found people's experience was dependent upon the unit in which they resided and we noted differences over the two days of our inspection, as different staff were on duty in some instances.

Staff in Windsor unit told us that that one person was due to attend a hospital appointment but no attempt had been made to ensure additional staff were on duty. In addition, following a GP visit, another person had to be admitted to hospital. Again, even though the nurse was informed of this, it was unclear whether this had been raised with the deputy manager so they could ensure additional staff were available to escort the person to the hospital. We brought this to the attention of the deputy manager and the consultant representative.

On the first day of inspection staffing in the Windsor unit was sufficient until prior to lunchtime when people needed two staff to assist with transfers. We saw staff co-ordinated between themselves how and who they would support whilst still having a member of staff in each of the lounges. We noted that the nurse was not available to help support the staff.

Within Windsor unit we were told that a member of staff must remain in the lounge at all times. However, there were at least four periods of 10-15 minutes when there was no staff member in the lounge. We found the activity worker was asked to stay in the lounge whilst all staff were supporting people. Although the activity worker was happy to stay in the lounge to help staff out, it meant she could not carry out her role as an activity worker.

A new carer (on the second day of their induction) was left in the lounge after lunch and told that she should call for assistance if someone needed help. We asked a member of staff (on their break) to help when a resident shouted that needed to go and stood up. The person returned to the lounge with the new carer supporting them. No permanent or agency staff were present to support the person. This was raised with a staff member that returned from their break a short while later and with the deputy manager, who said the new carer was not trained. This demonstrated risks to people's health and safety because untrained staff were left to care and support people.

On the first day of our inspection our observations within Tudor unit showed that the agency nurse was unavailable to support staff and people using the service until 11.00 am due to them administering medicine. The nurse acknowledged that whilst morning medicine rounds often took the longest there was the added difficulty in establishing who was who as they were not familiar with the people who used the service.

We also noted that staff were not always observant to the fact that people needed assistance. We saw one person who lived with dementia walking up and down the corridor, however there were no staff to take note of the person, which resulted in the person's dignity being compromised as staff were not available to assist them with personal care. We found there were insufficient staff to provide the support people required with their meals as they were not supported in a timely manner and spent a significant period of time sitting at the dining table after their meal, waiting for assistance to assist them into an armchair.

We observed one person who required a soft diet being offered crumble and custard for dessert, the person said they would like this dessert. A second member of staff intervened and advised the staff member that the person required a soft diet and therefore could not have the crumble. This meant that had the staff member not intervened the person would have been at risk of choking.

Staff views about staffing numbers were mixed and were reflective of the unit in which they worked and the use of agency staff which differed on a day to day basis. A staff

Requires improvement

Is the service safe?

member in Sovereign unit told us, "We always have three care staff, four when we are full." Whilst in Windsor unit the majority of staff were concerned about the staffing levels because at busy times of the day people had to wait until staff from the first floor or another unit were available. Staff said that the use of agency staff was helpful as this increased staffing numbers but that more consistency was needed to ensure that the same agency staff were used so that they became familiar with the needs of people.

We spoke with the provider and deputy manager and a representative of the consultancy firm about our findings on the first day of the inspection. When we returned on the following day they advised us that they had reviewed the deployment of staff over the three units to increase the consistency of care that people receive. They had put together a plan for the closure of Tudor unit moving occupants to one of the other units, following consultation with those using the service and their relatives. This was to promote the safety and continuity of care of people and to maximise the development of staff through training and enable the refurbishment of Tudor unit.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoken with said they had received training about safeguarding procedures as part of their induction training (e-learning – training via a computer) and knew where to find the procedures if required. They understood the type of abuse that could occur and their responsibility to report concerns to the nurse in charge in the first instance. Staff were aware of the external agencies such as CQC and the local authority, and that they could report concerns to them if the management team did not take action. A member of staff told us, "I would report it. If it involved the manager then there is a lot of support externally, we could contact CQC." Whilst another member of staff told us, "I would tell the nurse or the manager."

We saw that information about safeguarding people, which included contact details for contacting external agencies were displayed throughout the service; this helped to promote people's awareness of abuse and informed people how to alert agencies of their concerns.

We observed several occasions of people being moved, supported by staff, and found this was not always done safely. In the majority of instances people were moved safely; however in one instance a person was supported by staff who were new to their role and who had not completed the training that would ensure they moved people safely. We brought this to the attention of the deputy manager and representative of the consultancy firm who took action by issuing instructions that staff who had not received the appropriate training were not to provide this type of assistance. We observed on the second day of our inspection a recently recruited member of staff advising a colleague that they could not assist with moving and handling a person as they had not received the appropriate training, which showed that the directive had been acted upon and people's safety promoted.

We found risks associated to people's health had been assessed at the point of them moving to the service. Those included assessment for falls, moving and handling, and risk of pressure ulcers and malnutrition. The plans of care detailed the role of staff in meeting people's needs safely with regards to the use of equipment and we saw that where equipment was identified, such as sliding sheets, these were available along with pressure relieving equipment.

One person we spoke with told us that bed rails helped to keep them safe by stopping them falling out of bed. We found bed rails were used in some bedrooms but there was no capacity assessments completed in relation to the use of bedrails. Records did not show whether other less restrictive options had been considered, or whether the use of bedrails had been discussed with health care professionals. In one care record we saw that the relative had been contacted by the service's staff with regards to the use of bedrails and bumpers and had been advised that they needed to give consent for their use. A consent document was signed by the relative for the bedrails and bumpers to be used. The care plan did not show the purpose of the bedrails other than the person was at risk of falls, and what measures had been taken to reduce the risks associated with the use of bed rails, such as entrapment. There was no evidence of health care professional involvement or record to determine if this was in the best interest of the person.

We found another person's records included a consent form signed by their relative authorising the service to remove the footplates from a wheelchair when moving the person to reduce the risk of injury. The relative told us, "Footplates were removed from my [relative's] wheelchair

Requires improvement

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to avoid any damage to their legs as they have delicate skin, staff made me sign a consent form." The person's plan of care did not include the purpose for the removal of the footplates. There was no evidence of health care professional involvement or record to determine if this was in the best interest of the person.

We found call bells were available should people need to summon assistance. One person who used the call bell to gain help said, "If I need help I shout mostly. Most of the time they come quickly." Where call bells were out of people's reach people's records identified that the person was unable to use a call bell. In some instances sensory mats were used to inform staff that people were mobile so that staff could monitor their movement to ensure they were safe.

Corridors were free from obstructions and well-lit to enable people to find their way to their bedroom, toilet or the lounge. Records confirmed that equipment for moving people had been regularly maintained, which promoted people's safety.

We found within the Tudor and Windsor units that aspects of the environment were not fully maintained as carpets within communal areas were secured with tape to prevent trips as there were worn down threshold strips and tears in the carpets. We were advised by the provider that Tudor unit was being refurbished, which would include the replacement of the flooring.

Within the Tudor unit we noted that an external window in the dining area had a handle missing which meant there was no means of fully closing and securing it. One person told us, "When it's cold, it's cold, we pay for the heating but they hardly put it on, we have to pull the curtains closed."

During our inspection we periodically checked the room temperatures in the communal areas of Sovereign and Tudor unit and found the temperature was sufficient with regards to the promotion of people's safety and well-being.

One person told us that their bedroom within the Tudor unit was not warm, which meant on that morning they had not wanted to get up to early. We found that the maintenance person had looked at the person's radiator and had taken action to fix it several days earlier. We spoke with the provider and advised them that the person had told us that their radiator was still not generating heat. The provider contacted the maintenance person to look at it that day.

People we spoke with shared their views as to whether there were sufficient staff to meet their needs and keep them safe. Comments included, "Safe, definitely yes, you have your own room and can move about. There are enough staff for me but for someone else perhaps not, but you don't want too many around, they would be falling over one another. " "Safe definitely, it's very peaceful and I can go out when I like." "Safe, oh yes; only snag is you can't lock your door [so] anyone can walk off with anything. I have lost slippers and items of clothing. I would like to lock my room." "I feel quite safe here" and "staff listen and do you ask." Another said, "Staff help when they're free and not busy."

A visitor when asked if their relative was safe told us that they believed their relative to be safe as the home was secure.

Staff told us that they kept people safe by making sure the environment was clean and free of obstacles as well as checking on people.

Requires improvement

Is the service effective?

Our findings

Staff spoken with said they had received induction training when they first started which consisted of e-learning and shadowing. Training that staff had completed included: fire safety, infection control, health and safety, moving and handling, safeguarding, and a few had completed training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). A member of staff told us that they completed the e-learning at home in their own time as they were too busy at work to complete it. Staff training records showed gaps in people's training, which meant people, could not be confident that the care they received was provided by staff that had the appropriate knowledge and skills.

Induction records we viewed identified that the induction process for staff was not consistently applied, with staff using different tools to record their induction which were not always completed in full. We spoke with the deputy manager and consultancy representative who said that induction for staff had been identified as an area for improvement and that they hoped to introduce the 'Care Certificate' to be used for both new and existing staff. The Care Certificate, which has recently been introduced, is a set of standards for care workers that upon completion would provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support.

We noted on Windsor Unit that a new care worker was on day two of their induction and had no experience of working in care. From our observations the new care worker was neither supervised nor supernumerary to the staffing. Another member of staff who had worked at the service for over a year and was experienced in care told us she had completed the on-line training in moving and handling. However, she was still to attend the practical training in moving and handling. In addition, she said no one had observed her practice or assessed her competence when using a hoist and transferring people. The matrix which recorded staff training confirmed that staff had not in all instances completed moving and handling theory training, whilst others had not undertaken the practice training. The deputy manager confirmed that people's competency was not assessed on an on-going basis.

We spoke with an agency nurse who worked at the service when required. They told us their induction consisted of a premises check, fire safety, and an overview of the needs of those using the service, where care records were kept, and the management of medicines.

When we asked staff about the support they received the responses were mixed. Whilst some told us that management were supportive and approachable, others felt there was little support. One care worker said, "Nurses don't manage or support us. We talk to each other and agree how we're going to manage [they were referring to supporting people with transfers]." Staff also told us that if they have concerns about a person's health then the nurses will check them. However, they felt nurses tended to administer medicines, deal with GP's and other professionals, and provide staff cover in the lounge when staff needed to support people.

When asked about staff meetings and supervisions staff said meetings took place but were not able to say what was discussed at the last meeting. Records showed that team meetings had been held and minutes recorded the issues discussed. Records we looked at regarding the supervision of staff identified that many of the staff had been supervised recently this year; however for many this was the only record available. We found the deputy manager had been supervised just once at the beginning of the year. The deputy manager confirmed that observational supervision to assess the competency of staff had not been undertaken. Appraisals were found not to take place. The infrequency of supervision and lack of competency assessments and appraisals meant that the provider could not be confident that staff had the appropriate knowledge and skills to carry out their role and therefore could not assure themselves that people using the service had their needs met effectively.

Staff in some instances knew about the needs of people and how to support them. They were aware of people's preferred routines and interests. For instance, one staff member provided reassurance to a person who before being transferred to the armchair became anxious. They offered them reassurance and lots of eye contact and smiles. Thereafter, the person was happy to be supported to transfer to the armchair.

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

Is the service effective?

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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The deputy manager told us that there were six people who used the service that had a DoLS authorisation in place which had been granted by a 'Supervisory Body' (A supervisory body is the local authority of health board that is responsible for considering a deprivation of liberty). They told us that other applications had been made and they were waiting for their outcome. We looked at people's records that were subject to a DoLS and found that the provider was complying with the conditions where these had been applied by the 'Supervisory Body'.

We found that people's capacity to make decisions had not been considered individually for all aspects of their care. We found mental capacity assessments were not always in place for important decisions such as covert medication or the use of bed rails. We saw that family members had been consulted as part of the decision making. The PIR stated that ten people had granted powers of attorney to people other than themselves to make decisions about their care. We saw that family members had been asked to give consent to things such as the use of bed rails and for flu injections. This meant people were safeguarded in line with the MCA.

Some people's care records showed that an advanced decision about their care with regards to emergency treatment and resuscitation had been considered. In some records the Do Not Attempt Resuscitation (DNAR) had been completed correctly in that it had been reviewed by the person's GP following discharge from hospital and discussed with the relative because the person lacked capacity to make an informed decision due to living with dementia. However we found that these had not always been completed through the best interest decision process and there was no evidence that a mental capacity assessment had been carried out in regards to the decision. In some instances we found that the reason the person had not been involved in the decision had not been documented. The provider, in consultation with the consultancy firm, had identified within their action plan that MCA and best interest decisions needed to be clearly assessed and documented and were in the process of having DNAR's reviewed.

Staff's understanding of what was DoLS and MCA, and their role in supporting people varied. Two staff said they had received training in MCA. When we asked staff whether people in the Windsor Unit had capacity, in the first instance they said the majority of people lacked capacity. They said approximately four to six people were more independent and had the capacity to make decisions. Further discussions with staff highlighted that some people could make simple decisions about their care and daily choices about their meals, drinks, and how they wanted to spend their time. Also staff mentioned that at different times of the day some people were able to make decisions. Staff acknowledged whilst they accessed training via e-learning their understanding of what that meant in practice was not always consistent, as our discussions with staff identified.

Care records viewed for one person contained the DoLS authorisation in March 2015. However the plan of care for personal hygiene and mental capacity developed in August 2014 only stated 'DoLS in place'. The guidance for staff had not been updated to reflect how this support should be provided. For instance, it had not identified the triggers and behaviours that would indicate the person was agitated and what techniques staff could use e.g. 'offer a tea or squash and speak using simple words'. There were no prompts as to topics of conversation staff should encourage or times of the day when the person would be more responsive, which was evident in the authorisations. Despite this staff spoken with described the how they supported the person and used techniques consistent with the information in the authorised DoLS.

People within the Windsor unit told us they enjoyed the meals and food choices were good. Comments received from people included, "I love having hot meals" and "I had

minced crusty pie and veg". Another person said that her lunch was kept aside and warmed up once she was ready to eat (this person liked to get up around lunchtime) so her wishes were respected.

People's comments about food reflected that they did not always know what was on the menu and they had little opportunity to influence the menu. One person told us, "Food, no I don't know what we are having." When asked if they could have an alternative if they did not like what was being offered they told us, "I don't know." Whilst another person said, "Food, it's alright a bit monotonous" and, "The foods not bad." When asked if they had a choice, they responded that you took 'pot luck'.

We heard staff on Windsor unit on the first day of the inspection offer a choice of breakfast cereals, toast and cooked breakfast. However, this was not the case on the second day of inspection. One person thought she had not had breakfast and was a little hungry. A staff member said, "[Person's name] you had a bowl of cereal earlier and left half of it." No attempt was made to offer a snack as the staff member was busy updating records. To this the person replied "Well, it's no bother I'll stick with my tea. This showed staff that staff were unhelpful in meeting people's needs.

Staff told us that the provider regularly helped people to eat their meals. We observed this to be the case as one person was more responsive and ate their meal when supported by the provider rather than a member of staff. This happened during breakfast and lunchtime service.

Meals served on the first day of inspection were choice of chicken pie or faggots with runner beans, swede and mash followed by a choice of hot and cold deserts. The meals were served individually and alternatives were available for those who preferred to eat something else. The meals were presented well and looked nutritionally balanced. Meals prepared included soft and mashable meals.

Staff were seen offering people hot and cold drinks. A tray of glasses and a jug of squash was left on the dining table and staff were seen to encourage people to drink. We noted there were no snacks, fruit or biscuits available. The tea trolley had a selection of biscuits. The availability of snacks in the lounge would have allowed people to have a snack between meals.

Within Tudor we observed one person who had got up at 10.30am and heard a member of staff advising them that they could have toast or cereal as they had missed the opportunity to have a cooked breakfast, which meant the person's choice had been limited.

During the lunchtime meal we observed that people were not fully supported to eat and drink. During a period of one hour and forty minutes six people required support to eat, we observed that staff supported two people at the same time with their meal, which meant people were not supported in a personalised way.

Within Sovereign unit we noted that a member of staff attempted to assist someone to eat their meal. The member of staff offered appropriate encouragement; however the person declined to eat the first course, however with encouragement they ate their dessert. This showed that the member of staff provided appropriate support and care to ensure the person had something to eat. We also saw that people were supported to eat their meals and that staff sat alongside people and offered support at a relaxed pace. A relative told us that hot drinks were offered at certain time but people could ask for drinks at other times and staff would make them. People and their visitors told us that that there were two options offered at dinner time. One person told us, "My only complaint is the food could be warmer."

People's dietary preferences had been recorded and we saw an example of people's preferences being supported when a person was having bread and jam for their breakfast as recorded within their plan of care.

Records showed that an assessment of people's dietary needs had been undertaken. For example, the recommendation made by the dietician for the food and drinks to be fortified with creams and full fat milk was provided for one person and reflected in their care plan. Another person had been seen by a dietician as a result of weight loss. The dietician had recommended the person have a prescribed amount of milk which was to be fortified. This was recorded within the person's plan of care. People's weights were measured monthly and we found that health care professionals had been contacted where concerns about people's weight had been identified.

Records showed people's intake of food and drink was monitored and staff were observed to offer drinks throughout the day.

Requires improvement

Is the service effective?

People told us that staff made GP appointments or requested a GP visit when they were unwell. One person told they had an eye test recently. Another told us after their lunch that they had a GP appointment and needed to get ready to go.

Care records we looked at showed people were seen by the GP, SALT (speech and language therapy team), dentist and optician. Staff confirmed that any instructions left by the health care professionals was shared with them as the handover meeting, for example, increased monitoring, or a change of diet to soft food due to swallowing difficulties.

We met with a visiting health care professional who was called to see two people. They told us they found the staff were knowledgeable about the people using the service and their needs. The visiting health care professional told us that any instructions left with staff were followed.

Requires improvement

Is the service caring?

Our findings

People in Windsor unit told us that staff were kind and helped them in a respectful manner. People with limited speech responded well to their hands being held and stroked. Comments received included "The girls are very good", "They're very good; you can have a joke with some of them", and "The boss man [provider] is very pleasant." Whilst another person said, "They [the staff] are very nice people."

Visitors within Sovereign unit told us, "The care is very good; they are looking after [person's name]." They went on to say, "[Staff member's name] talks to [person's name] about sports as they used to like sports." A person from the unit told us, "I'm happy. The staff are trying to tune the television ready for the football tonight."

A visiting health care professional told us that they found staff to be caring towards people and knew how best to support them.

Throughout the inspection visit we saw people had developed positive relationships with staff. We observed people being supported by staff in a caring manner. People were heard laughing and chatting whilst sat in the lounge and when they were being supported. Staff sang along with people and some people hummed to the music.

We found that the use of agency staff meant it was difficult in some instances for people to develop caring and positive relationships as people did not have the opportunity to get to know the staff providing their care.

Staff communicated with people effectively and used different ways to offer support. For instance, we saw staff were at the same eye level with people who were seated and spoke clearly giving the person time to process the information and reply. One person who earlier was agitated appeared visibly happier once she was given her 'baby (doll) and was heard humming to the music that was playing. At meal time staff supported people to eat their meal in a sensitive and responsive manner. They took care to ensure the person's dignity was maintained. That showed staff were caring and provided personalised support that promoted people's wellbeing.

We observed someone reading a magazine and asking for the staff member's opinion on a dress. The staff member responded and chatted about the person's preferred clothes, colours and places they visited with their husband and family. People told us that their relatives could visit whenever they chose; we observed throughout the inspection that relatives visited people without restriction.

People we spoke with within Windsor unit were unsure what their plan of care was. However, when asked how staff helped them people were able to tell us how their care was provided. People told us that staff regularly sat completing records but were unsure why those records were completed.

People told us that staff always asked how they wished to spend their time. One person told us they were independent and that staff knew that. They went on to say that staff did ask them if they needed any extra help and they would always tell them, "I'll let you know when I need your help." Another person told us that they needed support when showering but were able to look after themselves at other times. People told us that staff respected their wishes and preferences.

Care records were not always reflective of people's preferences in relation to how they wished to be supported and were focused instead on the role of staff in relation to the care to be provided. There was no reference to people's preferred meals, interests or hobbies. The provider and consultant representative told us that plans of care were in the process of being reviewed with the involvement of people and their relatives to make them more personalised. A number of plans of care had been reviewed, which recorded the support needed and took account of people's views.

Records showed people's relatives were involved to a degree. For instance, when discussion was needed in relation to changes in the care to be provided and use of bedrails. We found relatives were contacted when their family member was unwell.

We were told people's relatives were involved in the development and reviewing of people's plans of care. A visitor in Sovereign unit told us, "I was recently involved in a care review." We found however that records did not identify if family had been involved in reviews and needed amending to state this. A second visitor told us, "They contact me if there are any problems."

People told us that staff treated them with respect and their dignity was maintained. They told us that staff knocked on doors before entering. People told us they

Requires improvement

Is the service caring?

could get up and go to bed when they wanted to. Staff provided us with examples as to how they promoted people's privacy and dignity which included drawing the curtains when supporting people with personal care and the use of privacy screens when using the hoist to move people.

We saw staff knocked on the bedroom door and entered when permitted to do so. If no response was heard staff entered the room and announced themselves. For instance, when the nurse was administering medicines, she knocked and entered the room and told the person that her lunchtime medicine was due.

We saw this to be the case several times throughout our visit. For example, privacy screens were used when the GP examined one person. However, we observed another person being assisted into an armchair with the use of a hoist where their dignity was not maintained, as staff did not appropriately cover the person to maintain their modesty.

Inadequate

Is the service responsive?

Our findings

We spoke with people about their care, one told us that agency staff were not aware of their lifestyle so had tried to get them up too early.

People we spoke with were not always consulted and involved in the planning of their care to ensure it was reflective of their preferences and lifestyle.

Records showed that people's plans of care and risk assessments were reviewed monthly by the nurse and signed. However there was no recorded evidence of what information was considered and reviewed. For instance, consideration as to the number of incidents when a person's behaviour had been challenging, or the frequency of falls or changes in their medicine. We found one plan of care had been updated following a deterioration in the person's health but no evidence that the person and/or their relative having been involved to ensure they understood how staff would support them to meet their new needs.

We were concerned about a person who after seeing the GP remained in the armchair in the lounge, slumped and unresponsive. The GP had told the nurse the person was to be admitted to hospital for further investigation and had arranged for an ambulance (which may arrive after 2hrs or longer). We noted that staff made no attempt to offer the person a drink or consider their comfort. When we asked the nurse and staff how the person was and whether they were safe and comfortable, we were told they were going to hospital.

Around 3pm we raised this with the person in charge and a representative of the consultancy firm that the person had been sat in the armchair since around 11am without a drink and appeared to be sliding. We acknowledge that they were due to go into hospital but staff had made no attempt to make them comfortable, ensure they were hydrated, or considered their well-being for example returning them to their bed for their comfort. The person in charge assured us they would check and make decision as to making the person comfortable.

On leaving the inspection at the end of day one, we checked on the person. They were alert and an agency staff had not long offered them a drink. The following day the nurse confirmed the person did go into hospital, had a number of checks and bloods taken and returned to the service.

We observed in Tudor unit on the second day of our inspection that people were supported to the dining table for their lunch time meal. We noted that one person who sat in a wheelchair at the table did so for one hour and fifty minutes. The nurse went to take the person to sit in an armchair; however there were no staff available to assist them move the person and therefore remained in their wheelchair whilst the nurse looked for assistance. We noted another person who lived with dementia at the same time, to be walking up and down the corridor, as though looking for something. The person's dignity was compromised as staff were not responsive to their needs. We brought our concerns to the attention of the deputy manager and a representative of the consultancy firm, who deployed staff to the unit. This showed that staff did not provide care that was reflective of people's individual needs.

We found people's plans of care did not include the necessary information to ensure people received care which reflected their individual needs and preferences. In some instances we found they contained inaccurate or conflicting information. For example one person's plan of care stated they had a mat placed next to their bed to promote their safety. However we found that the person now had bed rails in place for their safety. The person was also identified as requiring hourly observations in one plan of care but it was recorded within another that observations were to be carried out every 30 minutes. Another example was that one person liked to read magazines. Although this was provided it was not reflected in the plans of care which new and agency staff would not always know about if the permanent staff were not available to provide instruction. Another person with limited speech, liked to sit with the TV on and music playing. Again this was done in practice but new and agency staff would not know unless told by the permanent staff.

We found that daily monitoring records were pre-populated with the times of the day on a 30 minute or hourly basis, which meant the record staff completed, was not necessarily reflective of the actual time the observation

Is the service responsive?

had taken place. Staff were seen to complete the turning charts on one occasion retrospectively, i.e. signed to say checks were all done from 7.30am – 10am, once everyone had settled with a drink mid-morning.

We noted that people had long periods where they were seated in chair with little interaction from staff or activity to encourage stimulation. We noted that after lunch a football DVD had finished and that the credits were continually being repeated. Staff did not appear to notice and the DVD was not stopped until the activity organiser came into the room.

We observed one person who required a soft diet being offered crumble and custard for dessert, the person said they would like this dessert. A second member of staff intervened and advised the staff member that the person required a soft diet and therefore could not have the crumble. This meant that had the staff member not intervened the person would have been at risk of choking.

During our inspection a chiropodist visited the service, they told us they were due to see a number of people, however staff were unclear as to whom they were seeing, which showed that staff were not always knowledgeable about the needs of people using the service.

An agency nurse spoken with felt the service could benefit from having more up to date plans of care that were reflective of people's needs, preferences and interests. They felt staff knew people well but did not always have time to spend meaningful time with them.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were asked about the support they needed and how they wished to be supported. When we asked people how staff respected and promoted tailored care and support, one person said, "I like my sleep so I like to get up late and tend to stay up to 10pm." Staff would heat up the person's meal when they were ready to have it. Another person in the first floor lounge said, "The staff put on the television whenever I want to watch something. I think I'll watch 'High Society'." We saw staff put the DVD on for people in the lounge.

Staff in the main were familiar with the needs of people and how to care for them. Staff said they had received training in dementia awareness and knew how to support people whose behaviour could be challenging. Staff were observed to support people positively, through encouragement and conversations about things the person liked. For instance, meals provided met people's dietary needs. One person known to become anxious when they needed to transfer from the wheelchair to the armchair and needed a lot of reassurance. Over the two days the person was more responsive to three of the eight staff and the nurses because they knew how best to support the person as they needed a lot of reassurance and positive encouragement.

Food and fluid intake charts were completed for everyone. Staff circled what people had for breakfast i.e. cooked breakfast, cereal or toast, lunch much lunch was eaten, and amount of fluids consumed throughout the day and night. The fluid intake records were not always up to date as people had regular drinks but staff did not always note how much was drank as they were often busy.

People told us about some of the social events held included a Halloween party recently and a Church service. Within Sovereign unit we observed staff spending time on a one to basis with people, which included supporting someone to dance whilst another person was supported to have a game of dominoes. A visitor told us that, "Staff do try to accommodate people." Whilst a person who used the service told us, "They do games on the floor." (snakes and ladders etc.)

The activity worker told us that they went to all three units to do activities every day. Each unit had a selection of activities, books, board games, jigsaw and games which staff could use to stimulate people. They told us that at times they would support staff by staying in the lounge when staff needed to support people with personal care.

The activity worker had organised trips and outings to a garden centre, and undertook arts and crafts, music, and 1:1 activities such as reading and lunches out. The bonfire night party that had been planned included an external entertainer. They told us they had booked three pantomimes for the Christmas period and booked the Girls School Choir.

Whilst the activity person told us about the different activities organised for people there was limited record of

Inadequate

Is the service responsive?

this. We could not find a record of who attended or participated in activities; whether people had a say in what was of interest to them and feedback from the events to help plan future events.

We asked people what they knew what to do should they have any concerns. One person said, "I would tell the carer nicely what he or she was doing wrong." Whilst a second person told us, "I would talk to the staff but I don't have any complaints."

A visitor told us that they had raised a concern about a stain on their relative's bedroom floor. They told us they were impressed as the staff had cleaned and removed the stain before they had left the service. Another visitor told us, "There has been no cause to complain. I have no concerns." Whilst a third visitor said they had been given information about how to make a complaint. They told us, "I would tell staff if I was not happy." They went onto say that they thought staff would listen to them.

People told us that if they had any concerns they would speak with the staff on duty. In some instances they were not aware of the manager or the person in charge although recognised the provider and were confident to approach them.

Information about making a complaint was displayed within the service, which included communal areas and people's bedrooms.

We looked at the complaint records for two of the units and found that six complaints had been received within the year. The complaint records showed that the provider had taken action. The policy and procedure for the management of complaints stated the timescale and process for complaint handling, which included feedback as to the outcome of the complaints investigation. However we found that the records were not in all instances completed as to what feedback the complainant had received as to the outcome of the investigation or what future lessons could be learnt to prevent a reoccurrence. We informed the provider and the representative of the consultancy firm as to our findings.

Inadequate

Is the service well-led?

Our findings

People we spoke with about the leadership of the service told us, "It could do with a bit more activity." And, "Well led, not yet, they haven't got to that stage yet." Whilst a third person told us, "Well best it can be, considering shortage of staff."

The provider acknowledged that their governance of the service was ineffective and that as a result of visits undertaken by external health and social care professionals who had identified concerns with the service they had commissioned the services of a consultancy firm to support them in bringing about needed improvements. We were told this would include a governance system that would include quality assurance. They advised us of their intention to recruit someone to the position of 'quality co-ordinator' who once employed would be responsible for the overseeing of the system and audits.

Our observations showed that people did not receive a service that was timely and met their needs as the deployment of staff with consideration to their experience and training was not considered. We also found that there was a lack of leadership within the service which meant staff did not receive instruction and were not co-ordinated in order to people's needs were met on a day to day basis. We found there was not a clear system within the service for information to be escalated, which resulted in the service not being able to respond to events which occurred within the service.

We asked the deputy manager how staffing levels were determined and they showed us the tool used to determine staffing levels which was dependent upon the needs of people. However they told us, and records confirmed, that the assessment to determine staffing numbers was last reviewed in July 2015.

Staff felt management were not supportive when they raised concerns about staffing levels and the use of agency staff. We found the use of agency staff, coupled with staff that had recently commenced work at the service meant that people's care was not always effective or responsive as people's needs were not clearly understood and information in people's plans of care was not always accurate or consistent. The provider confirmed that additional staff had been recruited and that they were waiting for pre-employment checks to be carried out to ensure their suitability to work with people before they commenced work.

We spoke with the provider and asked them how they ensured themselves of the quality of care provided. They told us that they regularly visited the service and spoke with staff and people using the service. The provider told us that where issues were identified these were discussed with the individuals; however there were no record to support this.

The provider did not have quality assurance and governance systems in order to effectively monitor the quality and safety of the service provided. The provider informed us that they did not have a quality assurance system in place that monitored the service for example, staff training and its effectiveness and implementation, staff supervision and appraisal, and audits with regards to record keeping which included people's records. There was no evidence of audits being undertaken to be used as lessons learnt, with regards to risk, incidents, accidents and complaints that would support the provider and staff to reduce the likelihood of events reoccurring and therefore improve care.

A limited number of recent audits had been undertaken by the deputy manager to establish whether people's plans of care had been reviewed. An audit carried out in August 2015 had identified aspects of people's records which had not been reviewed. The September 2015 audit identified that the issues identified in the previous audit had not been acted upon. This showed that audits were not effectively used to bring about improvements.

We found the provider had not kept their knowledge up to date or accessed information from experts and other agencies about best practice and changes in regulations. For instance, the provider had signed policies and procedures to say they had been reviewed in September 2015 and were accurate; however they referred to outdated regulations. We also found that policies and procedures with regards to quality monitoring, the management of complaints and safe administration of medicine were not followed. This had a direct impact on the quality of care people received.

The provider told us that they supported the registered manager and monitored how the service was run; however

Inadequate

Is the service well-led?

there were no records to support this as the provider said they did not keep a record of their discussions. Staff records identified that staff had recently had a formal supervision, however these were not routinely in place and staff did not have their competency to carry out their role monitored or appraised, which impacted on the quality of care people received.

We saw records of recent audits of medicines management processes but the issues identified had not been fully addressed. On one unit the audit identified that records of medicines given when required were not fully completed – there had been no improvement since the audit.

The provider did not have an overview as to the care people received and therefore could not commit resources and develop the service.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recently asked people who used the service and their relatives to provide feedback on the service. Completed surveys showed that people were in the main satisfied with the care they received and were happy with regards to staff, however some expressed concerns stating that there were not sufficient staff. Surveys did identify that people did not always feel involved in their planning of their care or in the day to day running of the service, which included seeking people's views about the food and activities within the service and the wider community. Surveys also showed that people did not feel they were informed as to the outcome of external audits carried out by independent organisations, which included the CQC.

A visitor told us that they had been invited recently to a meeting, and that the next meeting was planned for later in the month. We looked at the minutes of meetings for people who used the service and their relatives. The most recent meeting held the month prior to our inspection, which the provider had attended, recorded people's views as to activities within the service and planned events. The quality of food was also discussed along with staffing levels and the use of agency staff.

A representative of the consultancy firm provided us with information about future planned meetings which would involve people who used the service and their relatives and would be chaired by someone independent to the service.

Staff spoke with told us when asked about the leadership, "The deputy manager is quite good, they always listen and I always feel supported." Another member of staff told us, "We have good nurses they are very supportive."

The provider within the PIR identified their planned improvements for the following 12 months. These included improvements to the environment to support people living with dementia. To support the registered manager to carry out their role they set out their intention for designated days for them to complete specific tasks and to be available to meet relatives.

The consultancy firm shared with us the action plan they had developed in conjunction with the provider, which included timescales to bring about improvements to the shortfalls they had identified.

Prior to our inspection we were contacted by local health and social care authorities responsible for the service they commissioned on behalf of some people who lived used the services at The Manor Care Homes. They told us that there had been a number of concerns that were investigated by the local authority safeguarding team.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that the premises were safe and secure to ensure people's safety. Staff were not following policies and procedures about managing medicines. The medicines policy was not in line with current legislation (disposal of waste Controlled Drugs). The provider did not ensure that the procedures followed by staff were in line with the provider's policy, which included: the process for administering and recording 'as required' medication, maintaining a full audit trail, recording the quantity of medicines, and assessing staff competency to administer medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive the appropriate support and training and were not sufficiently supervised or had their work appraised. The provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. Staffing levels and skill mix were not reviewed and adapted to respond to the changing needs and circumstances of people using the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People and other stakeholders were not sufficient involved or consulted in the assessment, development and review of care in order to develop a plan of care that was person centred.

The enforcement action we took:
We have issued a Warning Notice advising the Provider they must make the required improvements by 12 January 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have a governance system in place to assure themselves of the quality and safety of the service. The provider did not assess, monitor and mitigate the risks to people who use the service by use of audits and reviewing of records. The provider did not have effective systems to ensure people who used the service, other stakeholders and staff were kept informed and received feedback about the quality of the service and improvements required.

The enforcement action we took:
We have issued a Warning Notice advising the Provider they must make the required improvements by 12 January 2016.