Barchester Healthcare Homes Limited

Springvale Court

Inspection report

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27 June 2018

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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

This inspection took place on 11, 22 and 27 June 2018. The first day was unannounced and the other days announced. We last inspected the home between 23 May 2017 and 2 June 2017. We found the provider was meeting the regulations and rated the home as overall 'Good'.

Springvale Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 40 people in one adapted building. There were 40 people living at the home when we inspected.

The home had a registered manager. They were not present during this inspection as they had been seconded to another home temporarily. An acting manager and deputy were present throughout the inspection, supported by a regional manager. 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.'

During this inspection we found medicines administration was not safe. We found gaps in medicine administration records which meant it was not always possible to be sure people had received the medicines they needed. Records for medicines in stock were also inaccurate. Where people had been prescribed 'when required' medicines there was no up to date guidance for staff to help them decide whether thee medicines should be given. We observed some agency nurses did not follow best practice when administering medicines. The provider was acting to reduce the risk to people's safety. This included retraining for senior care staff and increased checks of medicines.

When we inspected the provider had already started making improvements with the management of medicines to ensure people received their medicines safely. Following our visits to the service we wrote to the provider to outline our concerns from the inspection and to request a robust action plan to address the concerns. The provider submitted a detailed action plan to the CQC which reflected the concerns we found during the inspection, as well as the concerns of local commissioners. The provider agreed to submit a monthly progress update. This will enable the CQC to closely monitor progress against actions identified in the improvement plan and in meeting the requirements of the regulations.

Staff told us staffing levels were not suitable to enable them to meet people's needs effectively. The dependency tool used to monitor staffing levels had not been updated regularly. Recruitment was not carried out in a safe way or in line with company policy. References lacked detail and were not received from staff member's last employer or the referees declared on application forms.

Incidents and accidents were not fully investigated to ensure appropriate action was taken and lessons learnt to keep people safe. Local safeguarding procedures had not always been followed as some incidents

had not been referred to the local authority safeguarding team to be investigated. Statutory notification had also not been submitted to the CQC for reportable incidents.

Staff told us the registered manager had provided good support. Records showed supervision and appraisals were not carried out in line with the provider's expectations.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. The provider held contradictory information about the number of people requiring a Deprivation of Liberty Safeguards (DoLS) authorisation. Some DoLS had expired and no renewal application submitted. Mental Capacity Act (MCA) assessments and best interests decisions were not recorded where people had restrictions on their liberty.

We found some people assessed as being at risk did not have care plans to help maintain their safety. For example, where people were potentially a risk to others due to aggression or were at risk of falling and injuring themselves. Other care plans were not up to date, lacked detail and were not person-centred. Evaluations were not carried out consistently and lacked meaningful information about people's current needs.

Actions identified in the Fire Risk Assessments had not been completed within the recommended timescales. We observed a potential fire hazard as the stairwell was used to store equipment. Although dealt with on the day of inspection, staff told us the equipment had been there for a long time.

Staff and relatives gave negative feedback about management and leadership of the home. Quality assurance was ineffective as the issues we found had not previously been identified and addressed through the provider's internal quality assurance systems.

You can see what action we are taking at the back of the full version of this report.

People and relatives gave positive feedback about the caring nature of staff. Although we observed interactions between people and staff were kind, people did not always have their needs met in a timely way.

The provider carried out a range of health and safety checks. We noted the home was clean, well decorated and well maintained.

Staff had competed training relevant to their role.

People were supported well to meet their nutritional needs. Where people required support, this was provided straightaway. Staff supported people to access health care services when needed.

Previous complaints had been dealt with appropriately in line with the provider's complaint procedure. People did not raise any complaints directly with us.

To address the concerns identified at the home, the provider had developed a 'home improvement plan.' When we visited the home, we found they were making progress with this plan.

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 managed safely. Action had been taken to reduce the risk to people of not receiving their medicines safely.

The provider was unable to evidence staffing levels were appropriate to meet people's needs in a timely way.

Recruitment was not carried out in line with company policy.

Incidents and accidents were not fully investigated or referred to the local authority safeguarding team when needed.

Regular health and safety checks had been completed. Cleanliness, décor and maintenance were to a good standard.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a lack of structured support for staff. They also told us they were not well supported. Most training was up to date.

The provider was not following the requirements of the Mental Capacity Act 2005 (MCA).

People received good support with their nutritional needs.

Staff supported people to access health care services when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed people did not always receive support in a timely way.

People and relatives gave good feedback about the staff team.

We noted that when staff interacted with people, this was done

positively.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were either missing, not up to date or lacked detail.

Care plan reviews were inconsistent and lacked meaningful information about people's needs.

The provider had not received any complaints about the home since our last inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance processes had not been effective in identifying and addressing concerns.

Staff and relatives gave negative feedback about the leadership and management of the home.

The provider had a comprehensive home improvement plan. We received positive feedback about the interim management arrangements at the home and the progress being made.

The registered manager had failed to submit the required statutory notifications following serious incidents.

Springvale Court

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.

The inspection was prompted in part by notification of an incident reporting a person using the service was alleged to have been subjected to restrictive practices without consent. The police are investigating this incident. We also received information from commissioners raising concerns about the safe management of medicines, compliance with the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and staffing issues.

This inspection took place on 11, 22 and 27 June 2018. Our first visit to the home was unannounced. Two inspectors carried out the first visit and one inspector was present on the other two days.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We had regular communication with the local authority commissioners of the service, the local authority safeguarding team and the clinical commissioning group (CCG).

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people who used the service and four relatives. We also spoke with the director of operations, regional manager, the acting managers, two senior care assistants and four care workers. We looked at a range of records which included the care records for four people, medicines records, recruitment records for five care workers and other records relating to the management and safety of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines administration at the home was not safe. We viewed medicines administration records (MARs) which contained numerous gaps in signatures. This meant it was not possible to confirm people had received the medicines they needed at the right times. This included medicines that were liable to misuse (controlled drugs). Accurate records were not maintained to confirm how much of each medicine was available and these records did not match the amount of medicines in stock at the home.

Some people received medicines only 'when required'. For example, one person had a medicine to be given as a last resort when they were experiencing anxiety. This required staff to decide whether these medicines were needed and should be administered. There was no up-to-date guidance available for staff to help them make this judgment safely and consistently.

Due to the concerns the CCG identified with medicines management, agency nurses were employed to administer people's medicines. This was a temporary arrangement until the provider's own staff had completed additional training and competency checks. We observed the agency nurses did not always follow best practice when administering medicines. For instance, signing MARs prior to administering medicines and leaving medicines unsupervised with people to take later. We raised our concerns to the acting manager who took swift action to deal with these matters.

When we started our inspection the provider had already been made aware that medicines administration was not safe. An action plan was in place to address the medicines issues at the home, to reduce the risk to people's safety. When we visited we found this was progressing well. Actions included retraining for senior care staff to eliminate the need to use agency staff, increased audits and reviewing the guidance available to staff. However, more time was needed to be sure these actions would be effective in delivering the required improvements.

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

All staff raised concerns with us about staffing levels. They told us they did not have the time they needed to provide the appropriate level of care for people and that this had a negative impact on them personally. One staff member commented, "Definitely not enough (staff). We do need more staff as we can't always help people. The staff are run ragged. This means the residents have to wait. Some people take two carers so if a buzzer is going off they have to wait, this happens often because we don't have enough staff. This was flagged up to [registered manager], she was aware. Acting manager is advertising for staff, she seems to be acting on it." Another staff member commented, "More staff would be an improvement, more staff on a night shift." A third staff member told us, "We are sometimes short of staff, sometimes it is only three (on a night). Most of the residents are buzzing, sometimes they have to wait." A fourth staff member told us, "We have all this paperwork and haven't got time to give the residents the care they need. We definitely need more staff", and, "There are two carers to do the residents, it is hard going. I am finding it really stressful, I am finding it hard to cope."

The provider used a specific tool called DICE to assess people's dependency levels, to check whether staffing levels were appropriate. We found the dependency tool had not been updated regularly to provide evidence that there were sufficient staff deployed. For example, the DICE for one person was completed on 18 February 2015 and had not been updated since. For another person the DICE assessment had only been reviewed once since 2015. The acting manager commented, "DICE is not right, they don't reflect people's needs. They should be done monthly."

The acting manager told us the usual daytime staffing levels were one senior and three care staff on each floor. However, on two of the three days we were at the home staffing levels were below this number. On the first day of our inspection there was a senior and two care staff on the first floor. Staff told us this had a direct impact on people's care. One staff member told us, "There are two carers for twenty people, we are breaking our backs. There are six men needing shaves, it is impossible for us to do what they want us to do. They [the provider] have been made aware." They went on to tell us that when they came on shift that day they saw one person was sitting with three jumpers on and another person hadn't been shaved for three to four days.

We observed how staffing levels impacted on people's care. On the second day of our inspection we observed that a person had to wait for 15 minutes to be transferred from their wheelchair into a comfortable chair in the lounge. A staff member, who was supervising the lounge, told us the person required two staff to support them. They said there were only two staff on duty and the other staff member had taken another person to hospital. The staff member said they had to wait for a staff member from upstairs to become free so they could help them with the transfer. Relatives shared other examples of when their family member had been left in a wheel chair for significant periods of time until staff were free to support them.

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

Recruitment was not carried out in a safe way or in line with company policy. Although Disclosure and Barring Service (DBS) checks had been completed for new staff, management had not ensured appropriate references were in place. DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with vulnerable people. This was the case for all five staff files we viewed. For two new staff one reference was incomplete. There was a hand- written note on the reference stating 'Need another ref. not complete'. However, no further reference had been sourced. For three new staff references were not from the referees declared on the application form. There was no information recorded as to whether the original referee had been approached in the first instance. Other references were either from friends who already worked at Springvale Court or colleagues from previous employment rather than a manager.

Accidents and incident investigations had not always been carried out to ensure people remained safe and lessons were learnt. We reviewed the accidents and incidents log for the home. We found staff and the registered manager were not completing incident forms in line with company policy. Some incident forms had missing pages and other pages were incomplete. We also noted the registered manager had not reviewed the forms to ensure appropriate action had been taken to keep people safe. For example, an incident had taken place due to one person displaying behaviours which challenged others. We found there had been no investigation to ascertain what had triggered this behaviour so that staff could intervene earlier to prevent future occurrences. Another person had fallen and staff had decided that additional observations were required to be carried out at night to ensure this person's safety. This person's care plan had not been updated to reflect these additional checks. We brought this to the attention of the acting manager who took steps to ensure the care plan was updated immediately.

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

From our reviews of incident and accident records we found some incidents of a safeguarding nature that hadn't been referred to safeguarding for investigation. For example, there were two incidents logged where people had been injured following an altercation with another person living at the home. We found no evidence these had been referred to the local authority safeguarding team to be fully investigated and to ensure the correct action had been taken to keep people safe. The acting manager confirmed they had also found a similar situation. They commented, "Some accidents needed to be safeguarded."

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff did not raise any concerns about safety in the home. Staff knew about the whistle blowing procedure and knew how to raise concerns about safety.

The provider completed health and safety checks to help maintain a safe environment. This included checks of fire safety, emergency lighting and water temperatures. Other checks were completed to ensure specialist equipment was safe to use, such as hoists used when supporting people to mobilise. Procedures were in place to help maintain people's safety in unplanned emergency situations.

We found the home was generally clean, well decorated and well maintained. The acting manager had identified some areas for improvement and had arranged for new furniture to be supplied. We observed domestic staff carrying out cleaning duties during our visits to the service. Staff followed infection control procedures including hand washing and the use of personal protective equipment when appropriate.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires that as far as possible people make 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.

We found conflicting information, within records and from speaking with the acting manager, as to how many people living at Springvale Court had a valid DoLS authorisation. The process for overseeing DoLS authorisation was not effective. For example, at the time of our inspection DoLS for some people had expired and no application had been submitted to the local authority. A significant number of DoLS applications were outstanding with the local authority. We found no evidence to show the provider had attempted to chase up progress with the local authority. We brought this to the attention of the acting manager who agreed to undertake an immediate review of all current and outstanding DoLS applications to ensure that the service was working within the MCA principles.

We found examples where people had restrictions on their liberty, such as bedrails and sensor alarms. We found MCA assessments and best interests decisions were not recorded to confirm this was the least restrictive option for the person. We also found MCA assessments in people's care records which did not specify the decision being considered. We discussed these examples with the acting manager. They commented that MCAs were on-going and "more need them that haven't got them."

Care plans did not accurately detail the support people needed with making choices and decisions. They also contained contradictory information about people's capacity. For example, one person's care plan started out by stating they lacked capacity to be involved in any decisions about daily activities and care provision. It went on to suggest there were decisions the person could make and where they couldn't a MCA and best interests decision would be completed. The care plan then provided general information about vascular dementia rather than the specific support the person needed with making decisions and choices.

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

Staff told us they had previously not felt supported working at the home. One staff member commented, "We didn't get much support from [registered manager]. I only had one appraisal and not many supervisions. I should have had one every three months. I don't recall having them that many times." Other

staff described how they were "stressed", "exhausted" and "finding it hard to cope" but hadn't previously felt listened to.

Staff did not have regular opportunities for structured support. The acting manager confirmed company policy stated for staff to have a minimum of six supervisions each year as well as a yearly appraisal. The supervision log and other supervision related records showed this had not been met. For example, of the yearly supervisions that were planned, 66% of those had not taken place. The acting manager was unable to locate any records to confirm that supervisions had been carried out during 2017.

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

New staff were required to undergo a 12-week induction period. Additionally, all new staff regardless of their previous experience were enrolled on the care certificate training course. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff working within health and social care.

Staff had mostly completed the training they needed. We reviewed the staff training matrix which indicated most staff were up-to-date with training. This included safeguarding, infection control, manual handling and fire drills. Some improvement was required to ensure all staff had completed fire evacuation training.

People's needs were assessed both before and after they were admitted to the home. This was to help the provider determine whether their needs could be met at the home. We viewed these assessments and noted there was no record that some important areas had been assessed. The template used to record the pre-admission assessment information included a section for 'cultural, spiritual and social' needs. However, in the records we viewed this had not been completed.

People were supported to meet their nutritional needs. People gave us positive feedback about the meals they received at the home. One person commented, "The food is smashing." We observed over lunch to assess people's mealtime experience. Tables had been set before people entered the dining room and background music was playing to help create a relaxing atmosphere. So that people could make an informed choice about what to have for lunch, they were shown 'plated up' meals to choose from. We observed some people in the dining room were provided with adapted crockery to help them to remain as independent as possible, such as a beaker to drink from. Although people required minimal assistance with eating and drinking, where help was needed staff provided it in a timely way. For example, help to cut up food or prompts to encourage some people to eat.

Staff supported people to access external health care services when needed. Care records showed people had received regular input from professionals in line with their needs. This included GPs, community nurses, specialist nurses, dietitians and speech and language therapists.

Requires Improvement

Is the service caring?

Our findings

Many people at the home were living with dementia. Involving people in developing their life history can encourage improved communication and develop a shared understanding of people's needs and wishes, to help provide care in a personalised way. We found life history documents in people's care records but these were poorly completed with lots of blank sections or very little detail. Care records also included a document called 'This is me.' The guidance on the document stated, 'this document will help you to support me in an unfamiliar place'. It covered areas such as personal care, mobility and eating and drinking. We viewed one person's 'this is me' which described them as independent in these areas despite their circumstances changing to the extent that they were now very dependent on staff for care and support. This meant the person might not be supported appropriately in other settings.

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

We spent time in the communal lounges observing how well people were cared for. We saw that when staff interacted with people this was done positively with staff showing people a warm and caring attitude. However, there were times when staff did not notice that people needed assistance. This meant people's needs were not always addressed in a timely way. On one occasion we noticed a person was slumped to one side in a chair. Although a staff member was present in the lounge, they were busy filling in paperwork and didn't notice this. After 30 minutes another staff member came into the lounge. We overheard then saying "[Person] you are going to hurt your shoulder pet." They went on to support the person to sit up straight and placed cushions behind them to make them more comfortable. They also spent time to chat with them.

On another occasion we noted some people were sat in a communal TV lounge on the first floor. A further group of people were sat outside in a seating area in the corridor. We noted the TV was on and that all the people in the lounge itself were asleep. Other people sat outside the lounge were awake and some were trying to turn their heads to peer round a doorway to see the TV. Although a staff member was sat at a desk nearby, they didn't notice this to support these people into the lounge. The acting manager told us a second TV had been ordered to address this problem and allow people additional choice of where to sit.

People gave us positive feedback about the care provided at the home. One person said, "They [staff] are very good. I like it here." Another person told us, "They are very kind, they help me. They are very helpful. If they haven't got what you ask for they find it. They don't make you feel that you are demanding attention." A third person commented, "I cannot fault them, they are very friendly. They have a bit chat." People told us they made their own decisions and could choose how they spent their day. One person said, "I can get up and go to bed whenever I want."

From speaking with staff it was clear they had a good understanding of people's needs. They readily described how they provided care that met people's individual needs. They had a good understanding of the importance of promoting dignity and respect whilst caring for people. They explained how they would

talk to people when providing personal care, always explaining what they were doing and gaining consent before providing any assistance.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not in place for some people identified as being at risk. For example, one person had been referred to the behaviour team for allegedly being aggressive towards staff and other people. We viewed this person's care records and found there were no care plans or risk assessments to guide staff about how to support the person with this. Another two people had been assessed as being at high risk of falls. We found these people did not have the required care plans in place to help keep them safe. The acting manager confirmed that a falls care plan should have been written for both people. Evaluations and reviews were not done consistently and lacked meaningful information. For example, the record of reviews tended to be a general statement, such as 'no falls or safeguarding issues to report.' This was then usually repeated each month.

Other care plans lacked detail and were not person centred. In some cases, care plans were missing and many care records were blank. For example, one person had a care plan as they were at risk of experiencing low mood. Their associated care plan stated, 'staff should offer reassurance and support to [person] at times they may feel upset or in low mood and this is best undertaken in the following manner'. Rather than describing the individual support the person needed the care plan had a general statement about how staff should attempt to lift the person's mood and wellbeing by 'recording what works well to achieve this for the individual resident'.

Another person's moving and assisting care plan stated that apart from assistance with getting out of bed, they were otherwise fully independent. We noted the person had a risk assessment for using a wheelchair. However, there was no reference to using a wheel chair in their moving and assistance assessment or care plan. The acting manager told us the standard of care planning was poor and that all care plans needed to be re-done. To guide staff as to the expected standards the acting manager had developed an exemplar care plan.

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

People had opportunities to take part in planned activities. The home employed an activity co-ordinator. We noted activities were on-going whilst we were at the service. This included a ladies group and ball games. However, we observed care staff had limited opportunities to spend time with people.

People did not raise concerns directly with us. However, they commented they were happy living at Springvale Court. One person told us, "Everything is good, there are no problems. There is nothing I can complain about." There had been no formal complaints made about the home since our last inspection. The provider had a structured approach in place should people want to complain.

Requires Improvement

Is the service well-led?

Our findings

We received negative feedback from all staff we spoke with about management and leadership in the home. The acting manager commented, "The residents are well cared for, I have seen some good practices. There has been a lack of guidance and leadership." Although we generally received positive feedback from relatives during our visits to the home, relatives raised many concerns at a recent meeting with the provider. These included concerns about lack of communication, laundry, staff attitude and personal care. They went on to say they had raised these with staff and the registered manager but 'nothing changes'.

We viewed the Fire Risk Assessment for the home dated September 2016. We were unable to categorically confirm that this had been reviewed. The acting manager told us a handwritten date and signature on the Fire Risk Assessment was evidence of a review. However, they confirmed this was not the usual approach adopted by the provider. The Fire Risk Assessment included actions coded as 'red - very high risk'. The associated guidance stated these needed to be addressed 'within one month' and were 'mandatory'. Similarly, some actions were coded 'amber' which needed to be addressed 'within three months' and were 'mandatory'. These actions had not been signed off as complete within these timescales.

During a walk around of the home we noted a large number of items were stored in a stairwell which could pose a fire hazard. This included an old lamp, a wooden trolley, a paint trolley and lifting equipment. Although these had been removed before we left the home, staff told us they had been there for a long time due to a lack of storage at the home.

We found incidents and accidents were not fully investigated to ensure appropriate action was taken and lessons learnt.

The provider operated a structured approach to quality assurance. This included a range of internal and external checks on quality and safety issues in the home, such as health and safety, infection control and documentation audit. A regional manager completed a monthly audit of the home and we saw from records these had been done consistently every month. However, the quality assurance systems had been ineffective as the issues we found, as well as commissioners, had not previously been identified and addressed.

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

Of the records we looked at we found that five incidents had not been notified to us. It is a legal requirement that certain incidents and accidents are notified to CQC. Additionally, the provider had failed to notify the local safeguarding authority of these incidents. This was brought to the attention of the acting manager who agreed to take immediate action to rectify and to notify those authorities involved. We are dealing with this matter outside of the inspection process.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The provider had implemented an interim management structure following the concerns the CCG identified. This included two acting managers and support from regional senior management. The home had also been placed in 'lockdown' which is an internal process the provider might implement when a home requires additional support to drive through improvements. This meant additional measures had been implemented for as long as needed until the required improvements have been achieved. Measures included three management walk arounds every day and daily checks of all records, such as food and fluid charts. The findings were then emailed to the regional director every day. Staff gave us positive feedback about the acting manager and said they felt she would improve the home. One staff member commented, "[Acting manager] is lovely, you can talk to her." Another staff member said, "I do think that [acting manager] will do a good job." A third staff member told us, "[Acting manager] is approachable. She is doing a really good job."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the safe management of medicines. Care was not provided safely because risks to people's safety and wellbeing had not been adequately assessed and managed. Regulation 12(2)(a), 12(2)(b) and 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse because the provider failed to operate effective systems to ensure concerns were investigated properly. Regulation 13(1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and mitigate risks to people's safety and to ensure action was taken to improve the quality of the care provided at the home. Accurate records were not always kept for each person. Regulation 17(2)(a), 17(2)(b) and 17(2)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have effective systems to provide assurances that staffing levels were sufficient to meet people's needs. The provide did not ensure staff were adequately supported to carry out their duties. Regulation 18(1) and 18(2)(a).