Ashwood Court Healthcare Ltd

The Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of The Grange Care Home on 26 July 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 6 and 7 March 2018 had been made. At that inspection the service was rated 'Inadequate' overall. Six breaches of Regulation were found during that inspection and the service was placed into special measures. At this inspection, the service was inspected against three of the five questions we ask about services: is the service well led, safe and effective. This was because the service was not meeting some legal requirements.

The Grange Care Home 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 Grange Care Home accommodates up to 28 people in one adapted building. At the time of our inspection there were 14 people using the service.

There was no registered manager at the time of our inspection. The registered manager left the service in April 2017, and a registered manager has not been at the service since this date. The service was being managed day to day by an interim manager who is referred to as the manager throughout this report. 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.

The Grange was last inspected in March 2018. At that inspection, it was rated as 'Inadequate' overall. A number of breaches of regulation were found during that inspection and the service was placed into special measures.

At this inspection people and their relatives continued to give good feedback about the service. We found some areas where there had been improvements, and some areas where sufficient improvement had not been made, including to areas previously identified resulting in continued breaches of regulation.

Previous issues relating to creams management and transdermal patches (a medicine applied to the skin) remained unresolved putting people at potential risk. Gaps in staff recruitment records had been identified by the manager as needing to be resolved but at the time of our inspection this had not been done.

Improvements had been made to risk assessments. These now provided clear guidance to staff of the identified risk and how to minimise the risk, however we needed more assurance that the progress made would be sustained. Staff understood their responsibilities in relation to safeguarding, and could identify warning signs they would look out for if they had concerns about people. Staffing levels had improved since

our last inspection. There had been improvements in relation to infection control; the previous odour in communal areas had been addressed. The provider had further plans to improve this area by replacing the carpets in the service. Accidents and incidents had been documented and improvements made when things went wrong.

People's needs were re-assessed when they were re-admitted from hospital. However, work was on-going and slow in re-writing people's care plans to ensure they were person centred and considered protected characteristics and preferences. Staff training and induction had improved, with new staff telling us the induction process gave them the tools to be able to do their role effectively. People were supported to maintain a balanced diet. The staff team worked with external healthcare professionals to provide people with on-going healthcare support. Improvements had been made to the premises to ensure there was dementia friendly signage throughout the home.

There was a strategy to drive improvement which was shared by staff and the management. People and their relatives were asked for their feedback about the service, and how to improve it. Staff understood their role in the organisation, and the management submitted the necessary notifications. The manager had developed good working relationships with healthcare professionals.

We found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The storage of prescription creams and application of adhesive medicines did not follow cream storage information.

Staffing levels met the needs of the people living at the service. Recruitment systems however were not robust.

Risks associated to people and the environment had been reviewed and improved.

Infection control procedures had been improved.

Staff understood safeguarding processes and how to protect people from potential harm.

There was improved learning from accidents and incidents.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs had been re-assessed prior to them being re-admitted to the service. People's healthcare needs had been escalated where necessary.

The provider had implemented an improved induction programme, which all staff new and existing were in the progress of completing.

Staff and the managers were working in line with the Mental Capacity Act 2005.

There had been improvements made to the premises with further improvements due to take place in the next few months.

People were supported to eat and drink sufficient amounts to maintain a healthy weight.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was no registered manager in post since April 2017.

Audits implemented had highlighted shortfalls however these had not all been addressed.

Staff told us there was a positive culture, although morale would improve once a permeant manager started.

The provider submitted statutory notifications to the CQC and displayed their rating.

The manager had formed positive working relationships with healthcare professionals.

The Grange Care Home

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 took place on 26 July 2018 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed information we held about the service, including the previous inspection reports. We did not request the service to complete a Provider Information Return (PIR). A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications submitted by the service. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with two people who lived at The Grange and observed their care, and spoke with two relatives. We spoke with a team leader, one care assistant, manager, the registered manager from a sister service, the provider; and the provider's consultant. After the inspection we received feedback from two healthcare professionals.

We looked at the care provided for three people who used the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. During the inspection we reviewed other records such as staff training and supervision records, staff recruitment files, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures. We displayed a poster in the communal area of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe at The Grange. One relative told us "Oh yeah, I think they're safe. I have no doubt that they're in good hands."

At our previous inspection, we found a number of concerns. We asked the provider to take action to resolve these, and they wrote to us to confirm they had. At this inspection we found there had been improvements, however there were areas previously identified where the provider had not made sufficient progress.

At our last inspection, we found that medicines had not always been managed safely. At this inspection, we found some areas had improved, but we identified some shortfalls. At our last inspection we found that records in relation to prescribed creams had not been completed for two weeks leading up to our inspection. At this inspection, we found records relating to people's creams had been completed and were being used correctly. Creams were stored in people's rooms, and had been risk assessed. However, on the day of our inspection, it was particularly warm and creams had not been removed from people's rooms until inspectors raised the issues with the management. Creams storage information stated that creams should be stored at or below 25 degrees celsius. On the day of our inspection, the temperature far exceeded this. We highlighted this to the manager, and they took action. The provider had purchased individual named baskets, for creams to be collected and stored in the medicines cupboard which was temperature controlled. At our last inspection we found medicines administrations records (MAR) for adhesive patches were in use, but not being completed the way they were designed to be. At this inspection we found that staff continued to incorrectly document and administer adhesive patches. We reviewed one person's MAR that detailed the site of the patch should be changed daily, and the same site should not be re-visited within 14 days. We noted that staff were documenting on a body map the site of application, they were not following the manufactures instructions of the possible sites of the adhesive patches, and they were simply rotating the patch from one arm to the other. Following the inspection, the manager informed us that all medicines trained staff had received training in the application of adhesive patches. The manager assured us daily checks were being completed on this area following the inspection to ensure people receive their medicines in the correct way.

The failure to manage medicines safely was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our last inspection found that medicines administrations records (MAR) were loose in a folder, without photographs of people. At this inspection we found MARs to be clear and well stored, with photographs of people on the front. At our last inspection, people who were prescribed regular pain relief were only receiving it on an 'as and when' (PRN) basis. There were no systems in place for helping people to express when they were in pain, which left people at risk of experiencing pain. At this inspection we found that people were receiving regular pain relief, as prescribed. At our last inspection, we found pressures, including a lack of staff on the morning medicines round resulted in the medicines round taking two and a half hours, and people not having the adequate time in between medicines. This increased the risk of people being over medicated. At this inspection we observed the medicines round took no more than 45 minutes, with

staff telling us people have the sufficient time in between medicines. Some people had 'as required' (PRN) medicines prescribed that were to be administered when they needed them, such as paracetamol for pain relief. At our last inspection, PRN protocols were being prepared to be implemented. At this inspection we noted people had PRN protocols in place.

At our last inspection recruitment processes were not sufficiently robust. This remained the same at this inspection. A comprehensive audit of personnel files had been undertaken by the registered manager of the providers other service. The audit was completed on 21st June 2018 and had been effective in identifying the shortfalls in files. However, when we inspected these findings had not all been rectified. Recruitment files we reviewed continued to fall short of the required records. There were still some gaps in employment records and references. This increased the risk of people being employed in the service who had not suitably demonstrated their previous good conduct. Disclosure and Barring Service (DBS) and identity checks had been made and documented. The DBS helps employers make safer recruitment decisions.

The failure to operate a robust recruitment process is a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, there were not enough staff deployed to meet people's needs. At this inspection, we found that staffing numbers had improved. Staff levels were now monitored through the use of a dependency assessment tool. This helped the manager to be sure that staffing levels met the needs of people. The manager told us there should be four carers in the morning, and three in the afternoon on duty. We reviewed the rota for the four weeks prior to the inspection and saw that staffing levels matched this. At times gaps on the rota were covered by agency staff, for example, on the day of the inspection an agency cook had been employed to ensure that the service was not disrupted in the absence of the permanent cook. The manager told us that they had asked the agency to provide consistent staff to cover shifts, this helped to ensure continuity for people. One staff member told us "We are having trouble at the moment with staffing, but we keep the floor covered with agency. We have got to the point where we have regulars back so they are familiar with the residents which is nice." There had been no further complaints about staffing levels since our last inspection. The provider and the consultant assured us that the dependency assessment tool would be used to ensure staffing levels remained appropriate when new people came to live at the service.

At our last inspection, we found the provider failed to mitigate known risks to people, and protect them from avoidable harm. At this inspection we found improvements in this area. At our last inspection, people were at risk from unsafe care and treatment because staff did not follow procedures in risk assessments, and risk assessment had not always been updated to reflect people's changing needs. At this inspection, we noted that all risk assessments had been reviewed and updated and considered a number of risks including falls, skin integrity and communication. We noted documentation had been reviewed and updated when one person returned from hospital following a fall. The person's risk assessment had been updated to indicate they were at higher risk of falls, and included changes to the person's mobility and how staff should support that person to remain independent.

At our last two inspections thermostatic valves had not been fitted to taps. This placed people at risk of scalds. Following our last inspection we received assurances that the boiler temperature had been reduced and thermostatic mixer valves were being fitted. At this inspection we found that this had taken place and thermostatic mixer valves had been installed. Regular temperature checks were being completed and water was within the safe range. This reduced the risk of people being scalded.

At our last inspection two kitchen refrigerators had temperatures with recordings higher than the

recommended safe level and records were not consistently checked. Some food stored in these refrigerators was out of date or incorrectly labelled. At this inspection, these refrigerators had been replaced, temperatures were checked and recorded in the correct way and food was correctly stored in line with the Food Standards Agency guidelines.

At our last inspection no fire drills had been carried out since our inspection in July 2017 and personal emergency evacuation plans (PEEPs) had not been updated. At this inspection fire alarm tests and evacuation drills were recorded. PEEPs had been updated to show changes in some people's mobility. There were now comprehensive documents which gave clear guidance to staff.

At our last inspection incident forms were completed although there was no evidence that lessons were learnt when things went wrong. A falls audit tool was in place, however this information was not used to update care records or risk assessments. At this inspection incident forms and audit tools continued to be used, improvements to identifying lessons learnt and reviewing risk had been made. Accidents and incidents were monitored, recorded, reviewed and discussed during regular clinical governance meetings. Care records and risk assessments were reviewed and updated to minimise the risk of reoccurrence. Equipment and utilities including hoists, the passenger lift, fire extinguishers and lighting, gas and electricity had all been safety-tested and maintained. Legionella testing had taken place in line with national guidance.

At our last inspection we found the environment was not sufficiently maintained to keep people safe and placed people at risk of injury and infection. Previously we found one person's bedroom in an unacceptable condition. There was a broken radiator cover, stains on the carpet and walls and a chair which was soaked in urine. At this inspection we found that many improvements had been made. The person's room had been cleared, the carpets and radiator covered removed and was in the process of being re-decorated. The consultant told us about plans to further improve the environment by replacing a bathroom with a wet room and replacing the carpets in communal areas. The provider also told us they planned to replace bedroom carpets. During our inspection of the premises the boiler cupboard was locked, unoccupied rooms being used for storage were locked and linen was stored correctly in the linen cupboard. At our last inspection the sluice room was not suitably maintained. At this inspection improvements had been made; the hand wash sink was now accessible with appropriate hand wash facilities, the sluice sink had been cleaned and the room was clean and tidy. The risk of the spread of infection had been minimised; disposable aprons and plastic gloves were available for staff and hand soap, antibacterial gel and disposable paper towels were available in toilets and hand wash facilities.

Staff had received safeguarding training, and were able to identify and report any concerns. One staff member told us "I would look for a change of mood, withdrawal, or fear if they saw a person coming. It could even be that they remind them of someone they used to know. I would look for emotional, physical, financial abuse, psychological. I would immediately report it to whoever is above me." The manager had completed referrals to the local authority safeguarding team where appropriate.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection people were not consistently protected from avoidable deterioration of their healthcare conditions. Following our inspection, the local authority shared concerns with us that the service had failed to respond to people's changing and deteriorating healthcare conditions. However, at this inspection, we found that staff had worked with healthcare professionals, escalating concerns regarding changes and deterioration in conditions, and had improved one person's pressure wounds. Staff told us that the person's skin integrity had improved, and the person's documentation detailed information from a healthcare professional stating that the wound had 'healed very nicely'. The person's care plan had detailed guidance on how to support the person with their pressure area, including what to do if staff noted any deterioration, and how to report it to. Staff told us they now understood how to identify concerns relating to pressure areas and how to escalate concerns. We observed the person had the correct equipment in place to support their pressure areas, in the form of an airflow mattress. We checked with staff, and saw this equipment was being used appropriately at the correct settings. At our last inspection, there were scant records of cream applications to support the person's skin integrity. At this inspection, we observed cream applications were being recorded appropriately.

At our last inspection, staff had failed to adequately record urine input and output for a person with a urinary catheter. At this inspection, no one at the service had a catheter in situ. However, during this inspection, we reviewed fluid chart documentation, and saw that it was being completed. During our inspection, we observed staff offering people fluids throughout the day, and offering ice creams to help keep people cool in the hot weather.

At our last inspection, people living with insulin controlled diabetes had not been supported to maintain their blood sugar levels. At this inspection, there was no one at the service who was supported to control their diabetes with insulin. People living with diet controlled diabetes were identified in the kitchen as needing modifications to their diet. Staff were aware of which people required this support, and the manager ensured that kitchen staff were aware of modifications required.

At our last inspection, there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to the failure to assess, monitor and mitigate risks to people's health. At this inspection, we found the breach had been met, however we cannot be certain that this practice is embedded at the service, and therefore it remains an area for improvement.

At our last inspection we found there was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a lack of suitable arrangements to ensure that people were supported in the right way to give informed consent to their care and treatment. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection we found there were improvements in assessments and records; MCA assessments had been made for specific decisions and associated best interest decisions had been made in consultation with professionals and documented the least-restrictive practice considered. On the morning of our inspection a best interest meeting was taking place with a person's GP and relatives present. During the inspection staff and managers demonstrated that they understood the principles of the MCA, we observed verbal consent being sought and choices offered when staff were supporting people such as where they would like to spend their time and what they would like to drink.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The manager had applied for DoLS authorisations when required, and any specific conditions attached to authorisations were being met.

At our last inspection, we found a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to the failure to ensure staff were trained and competent to be wholly effective in their roles. Staff had not received training in topics such as dementia awareness or end of life care. At this inspection we found that training had improved. Staff had completed dementia awareness training and most staff had completed end of life training, with others booked in the weeks following the inspection. Staff were able to demonstrate learning from the training courses, and told us how they implemented them in their daily routines to support people. After the inspection the provider sent a list of planned training dates. Staff continued to receive a range of mandatory training in subjects such as moving and handling, safeguarding and health and safety. At our last inspection senior staff and managers were recording clinical observations to help in making decisions about people's health and any treatment needed; they had not all received appropriate training. At this inspection, this practice was no longer taking place and management told us there was no plan for clinical observations to be re-introduced. They were now completed by visiting health professionals.

At our last inspection staff new to working at the service were not fully supported with a robust induction process. At this inspection the consultant told us about the new process that had been introduced. They showed us the 'induction passport'; a three month introduction to working at The Grange. It contained information about the services' policies and procedures; the skills for care code of conduct for care workers; works books with tests on topics such as safeguarding, dementia, dignity, MCA and DoLS. The provider's new induction training was designed to meet the Skills for Care standards for the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. They told us that all staff, new and existing, had been asked to complete these packs. New staff were allocated a mentor and spent their first week shadowing existing staff, reviewing and assessing their training needs with the manager and completing mandatory training such as fire safety and manual handling. Their progress was reviewed during their three month probation period. A supervision process had been introduced. The consultant was supervising the manager and the manager supervised other staff. They told us they envisaged this being reviewed once the new manager was in post, with other members of senior staff being responsible for supervising staff. The manager told us they had also introduced group supervisions with senior staff, where they focused on different topics. For example, they had recently had a session with a focus on observations from audits. A new staff member told us the induction programme had been 'good' and that it equipped them for their role.

At our last inspection there was little adaptation to the premises to make it suitable for older people or those living with dementia. At this inspection we found there had been some improvements. There were pictures displayed of actors and actresses from times gone by in the dining room that could help

conversation and spark memories. There was also clear signage on doors to help people identify rooms such as the lounge, dining room or toilets. In the lounge there was a picture display of the date, season and weather. There was a menu displayed on the wall detailing the food choices for the day, this is an area we discussed with the manager that could be further improved. The manager informed us they were in the process of working with healthcare professionals to develop picture cards to support people with limited or no vocabulary to make food choices.

No one new had been admitted since our last inspection. However, the manager had re-assessed people's needs prior to them being re-admitted to the service, from hospital. The manager assessed people whilst still in hospital and ensured that their documentation was accurate before they were re-admitted to the service. The documentation we reviewed, contained information relating to people's protected characteristics including their religion and marital status. The manager and the consultant informed us that they were in the process of reviewing all residents care plans, and re-writing them to reflect their preferences. We reviewed the completed care plans and saw that they were more person centred.

People told us they enjoyed their lunch. Some people preferred to eat in their bedrooms, and where they required support to do this, we observed they received it. Following feedback at a resident and relative meeting, the dining room was moved to its previous location, providing more space in the lounge for people to relax and a designated area for the dining area. We observed people being offered drinks regularly throughout the day, and being given the choice of a hot or cold drink. People in their rooms, had a supply of drinks and the team leader checked on them regularly to ensure they received sufficient fluids. Minutes from the most recent residents' meetings noted people were happy with the menu and had a 'good selection of fresh cakes daily'.

Requires Improvement

Is the service well-led?

Our findings

At our last two inspections the service had not been well-led. At this inspection, we found improvements in some areas, however sufficient progress had not been made to ensure that suitable arrangements were in place to enable to service to reliably meet regulatory requirements.

There was no registered manager; and there had been no registered manager since April 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider had not made suitable arrangements to have a registered manager in post for an extended period of time. This had contributed to the problems we found in the last three inspections. The management team informed us that changes implemented by the consultant and the manager had impacted on the culture of the service. One staff member told us "I feel we are on the way up from where we started and I think staff morale is up from when we started. It will be a lot better when we get a permanent manager. That's what brings staff moral down, having a lack of leadership and knowing the manager is moving on. Then things will feel more settled."

The failure to comply with conditions of registration is a continued breach of Regulation 33 of the Health and Social Care Act 2008.

At our last inspection, the manager and consultant had an action plan that had been poorly prepared and implemented and had led to continuing breaches. Whilst improvements had been made since our last inspection, we found two continuing breaches. During the inspection, we shared concerns we found with the manager and providers consultant, and they were corrected, for example the storage of creams, and the application of adhesive medicines. The consultant assured us that these would have been picked up in the medicines audit scheduled for the following day.

At our last inspection there was a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014. This was because a number of checks and audits had been introduced, however they had failed to recognise or address many of the shortfalls in the safety and quality of the service that we found. At this inspection we found improvements had been made, but further improvement was required.

Audits had not been wholly effective in identifying shortfalls and ensuring that action had been taken to address issues. For example, a comprehensive medication audit had been completed on 13 July 2018, following the introduction of the new medicines system. This had identified a number of actions to be achieved by 27 July 2018. For example, it was identified that action was required to improve transdermal patch (a medicine applied to the skin) application charts and record sheets. This had not been actioned by the time of our inspection. A comprehensive audit of all staff personnel files had taken place on 21 June 2018, this had identified the shortfalls that needed to be addressed. However, at the time of our inspection

there was no evidence to show that these actions had been taken.

The failure to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

A number of other audits such as hand washing, wound care, accidents and infections were in place. As a result of the improved oversight the manager was able to demonstrate that falls had been reduced and people's skin integrity had improved. A care plan audit had taken place in July 2018. This audit identified areas that needed addressing, with the manager completing an action plan in order to address the issues. Monthly governance meetings were ongoing with the management team and consultant. These were intended to increase oversight of the quality and safety of the service, however had not been wholly effective in addressing the areas identified during our inspection. During the governance meeting the home managers action plan was reviewed and identified actions that had been completed and those continuing to require focus. For example the actions from the fire risk assessment has been rectified in June 2018. The infection control audit completed in June 2018 had a number of areas to be addressed. These had been allocated to a specific person with a target completion date and once completed, were signed off.

Feedback had been sought from people and relatives through questionnaires and meetings. The consultant told us they planned to introduce a schedule for regular quarterly feedback questionnaires from different parties, such as people, relatives, staff and health professionals. This would be based on the areas that CQC inspect and they intended to analyse this to produce an action plan. The questionnaires that had been completed offered positive feedback. Residents' meetings were held as another method for gathering people's views and input about the service. Meeting minutes reviewed from the most recent residents' and relatives' meetings focused on food; people's preferences and what they wanted to add to the menu. The manager also updated people about the provider's recruitment progress and the use of agency staff.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The manager had notified the Care Quality Commission of important events as required. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the service and the provider had displayed the service's rating on their website.

The manager had developed good working relationships with local health and social services. This included links with safeguarding, the community mental health team, the GPs and any visiting healthcare professionals. The manager told us following our inspection, that staff had been booked to attend training courses run by the local commissioning group. The manager had details for the registered managers' forum to share with the new manager who was due to start in August 2018.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The registered provider failed to ensure there was a registered manager in post.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure medicines were stored and administered safely.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to assess, monitor and mitigate risks to the quality and safety of the service.

The enforcement action we took:

TBC

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to operate a robust recruitment process.

The enforcement action we took:

TBC