Porthaven Care Homes LLP

Prestbury 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 caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection on 12, 13 December 2017 and 8 March 2018 was unannounced. There was a delay in returning to complete the inspection partly due to an outbreak of influenza within the home. On the last inspection which took place on 18, 20 21 April 2017, 26 May 13, 14, 21 and 22 June 2017 we found breaches of regulations 9, 10, 11, 12, 13, 14, 16, 17, 18, 19 of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014 and a breach of Regulation 18 of the Registration Regulations 2009. The service was placed in special measures rated inadequate.

On this inspection we found the provider had met the legal requirements of regulations 9, 11, 14 and 19. The provider remained in breach of regulations 10, 12, 13, 16, 17 and 18 of the Health and Social Care Act Regulations.

Following the last inspection, the provider sent us an action plan to show the Commission what they would do and by when to improve to at least good. The provider demonstrated they had met the positive conditions which were served by the Commission. We also met with the provider and discussed progress being made to meet the breaches found.

Prestbury Care Home is a 75 bedded care home. There were 53 people living in the home at the time of this inspection. 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. It has three units over three floors called Haddon, Gawsworth and Capesthorne which have separate adapted facilities. Gawsworth specialises in caring for people living with dementia. There was a registered manager in post 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.

On the last inspection which commenced on 18 April 2017 we found the provider was in breach of regulation 9 Person Centred Care. This was due to care plans not providing enough detailed information about the person's preferences, likes of dislikes. Some risk assessments/care plans required to deliver person centred care were absent. On this inspection we found improvements had been made and the provider was no longer in breach of person centred care. Care plans were no longer absent and some person centred information such as a person's place of birth, family member's names, previous pets and places of interest were seen in the care plan.

On our last inspection which commenced on 18 April 2017 we found the provider had not mitigated risks when they became aware of them. We found some improvements on this inspection but continued to find risks which were not mitigated. For example, we found a trailing oxygen pipe on the floor and although there

was a risk assessment for having oxygen in the home there were no risk assessments in place for the storage of oxygen in people's bedrooms. A new computerised system to manage recording of administration of prescribed medicines was being implemented in the care home at the time of our inspection. We found one person had not received their prescribed medicine on our inspection. The provider remained in breach of Regulation 12 Safe Care and Treatment.

Improvements were seen in safeguarding people as unexplained bruising was being recorded, reported and body mapped however, some complaints seen in the complaints file were safeguarding concerns which had not been dealt with appropriately. There was a repeated breach of Regulation 13 Safeguarding.

On the last inspection we found concerns in relation to people having appropriate foods to meet their needs and a breach of regulation 14 Nutrition and Hydration. We found improvements on this inspection and the provider was no longer in breach of this regulation.

Complaints and concerns had not been dealt with consistently on the last inspection with a breach of Regulation 16 Complaints. We received some concerns prior to the inspection that concerns raised were not being dealt with effectively. On this inspection there was no contemporaneous record to demonstrate how each complaint was dealt with. This is a continued breach of Regulation 16 of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We found the provider was in breach of staffing on our last inspection due to the concerns about the deployment of staff and staffing numbers in the home to meet people's care needs. Prior to this inspection we received anonymous concerns about staffing and on inspection we observed staff taking six minutes to respond to a call bell. On further inspection of call bell response times we found the provider remained in breach of Regulation 18 Staffing numbers.

We received positive comments and some negative comments about staff who were delivering care. People's dignity was not always being upheld. The provider remained in breach of Regulation 10 Dignity and Respect.

The provider had recently brought in a new regional manager to supervise the registered manager and drive improvements. We found their leadership effective during our inspection. The registered manager had not acted in a timely manner, dealt with complaints robustly or provided the leadership necessary to drive improvements since the last inspection. There was a continued breach of Regulation 17 Good Governance.

Activities were being provided including trips out but this was limited due to the staffing ratios required according to staffing within the home. Leisure and Wellness staff were seen providing activities on the inspection.

The home were following a Mental Capacity Framework but further improvements were needed to ensure best interests decisions were in place for decisions people had difficulty making due to their impaired mental state.

Training had improved to include a dementia specialist trainer who had undertaken staff training and a seminar within the home. Staff were receiving supervisions and induction.

Staff had knowledge of safeguarding people from abuse and knew how to report any concerns.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not enough staff to meet people's care needs all of the time.

Further improvements were required to ensure all risk assessments were robust including for previous convictions.

People who could converse with us told us they felt safe in the care home.

Is the service effective?

Requires Improvement

There service was not always effective.

Staff training was not always robust as additional training needs following competency checks had not always been followed up.

People were not always being supported to eat or drink appropriate foods/drinks according to their dietary requirements.

The service had a MCA framework and DOLS were being applied for when appropriate.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always being promoted.

Staff interactions were warm and compassionate.

People were being encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The system of managing complaints was not robust.

Care plans described people's backgrounds, preferences, likes and dislikes.

Some people were engaged in activities within the care home.

Is the service well-led?

Inadequate

The service was not well led.

The quality assurance systems were not robust enough to identify all of the concerns on this inspection.

We raised concern about the quality and effectiveness of some of the systems within the home such as the complaints system.

The registered manager had not always acted in a timely manner or always demonstrated they were transparent in their approach.

Prestbury 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 checked 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.

We inspected to check if there had been enough improvements since our last inspection on 18, 20 April, 26 May, 13, 14, 21 and 22 June 2017 in line with our special measures guidance.

Since our last inspection we received information of concern about staffing levels and how concerns/complaints raised with the management were being dealt with.

This inspection took place on 12, 13 December 2017 and 8 March 2018. The inspection was unannounced. The inspection team included two adult social care inspectors, an expert by experience and a specialist nurse advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed all the information we held about the service such as notifications the provider is required to send to us by law and concerns received. The most recent PIR (Provider Information Return) sent to us was dated 7 July 2016.

During this inspection we spoke with 10 people who lived in the home, 6 relatives, 4 visitors and 14 staff including the registered manager, regional manager and the chef. We viewed five people's care plans including their associated records such as daily entry sheets and medication administration sheets (MARS). We undertook a Short Observational Framework Assessment (SOFI), viewed four staff recruitment files and records related to staff who had previous convictions/restrictions on practice.

We received information from the Local Authority and Commissioners to obtain their feedback. We also viewed the most recent quality assurance visit report from the Local Authority and Commissioners.

Requires Improvement

Is the service safe?

Our findings

When we last inspected on 18 and 20 April, 26 May, 13, 14, 21 and 22 June 2017 we found the service was unsafe. We served a notice of decision imposing conditions on the provider's registration. The provider met the conditions which were then no longer required. On this inspection we found improvements had been made in reporting unexplained bruising and body mapping. We found some safeguarding concerns had not been identified. The provider remained in breach of Regulations 12, 13 and 18 staffing levels on this inspection.

We asked people if they felt safe with the care staff looking after them. One person who lived at the home said, "I feel I am safe, being looked after and being fed." A second person told us "I am only here for a short period, will go home when my boiler is repaired. Feel safe and secure here." A third person told us "I have sold my house. This is the right place for me. Couldn't be better." A fourth person said "I like it here. I like the staff. They protect me, I feel safe, for example, when a hoist is used. "

We found safeguarding procedures had improved within the care home. The registered manager had ensured all unexplained bruising was being body mapped and medical advice was being sought from the visiting general practitioner to distinguish between bruising or purpura which is a skin complaint. Incidents were being logged with photographs seen with the incident form to illustrate the injury/mark to a person. The system of reporting and analysing incidents was more robust. This is important in distinguishing between what is related to a person's skin complaint and what may be marks/bruising caused by another means.
We found some safeguarding concerns had been dealt with as a complaint and not a safeguarding. For example, there was an allegation made by a person receiving care they had been shouted at by a care worker and a second complaint by a person stating an agency staff member had been "hurting" them. We were informed the action taken by the registered manager was to speak with the staff member and contact the agency to report this. The provider had not followed their own Safeguarding policy to protect people from abuse.

This is a Breach of Regulation 13 Safeguarding Service users from Abuse and Improper Treatment of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

We received concerning information regarding staffing levels within the care home prior to the inspection. Three staff members we spoke with during the inspection also raised concern about staffing levels. One staff member told us they were concerned they are unable to always respond to call bells and it concerned them that one day it may be an emergency. Another staff member told us they struggled to provide care for people due to the majority of people needing two staff. A third staff member told us they had raised concern with the registered manager about staffing levels but nothing was actioned. We asked the registered manager about staffing levels and they responded "staffing is fine". We asked about staffing in communal areas on the middle floor and the manager's response was "There's always a staff member in the lounge on the middle floor". We were informed by the registered manager there were four care staff to deliver care on the dementia care unit. We found the dependency levels on the dementia middle floor included two people

who required 15 minute observations, one person requiring 30 minute observations and a fourth person who required three staff members for all transfers using a hoist. There were at least five people who required two care staff to support them with their care. This meant in the event two people were requiring two care staff to support them at the same time, the staff member in the lounge would be left to supervise people who were on observations and to respond to other people would needed them. We followed staffing levels as a key line of enquiry and pressed a call bell to test the response time. We calculated it had taken six minutes for staff to respond to the call bell being activated. We then asked to view the call bell response times which were sent to us following our inspection. This evidenced response times up to 34 minutes in duration. The purpose of a call bell is for people to alert staff in an emergency or if they require care. We were concerned that the time taken to respond to call bells due to staffing levels/deployment of staff was placing people at further risk of harm in the event they may have needed urgent assistance.

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

We checked the management of medicines in the home and observed a medicines round. The nurse undertaking the medicine round checked all identification photographs for each resident prior to administering the medication, the trolley was kept locked throughout and when unattended. We observed medicines were being signed for in line with best practice only after each person had taken their medication. Medication administration sheets (MAR) sheets were all correctly filled in except one entry at 6am that morning. This was an eye ointment for one person which had not been administered. We also checked the Controlled Drugs register and drugs returned books which were up to date.

Following the inspection we were informed by the provider they were implementing a new electronic system of managing medicines within the care home. This had begun to be implemented during our last day of our inspection on 8 March 2018.

Recruitment practices were checked in the care home. We looked at four staff recruitment files and found they contained evidence of safe checks being undertaken including a Disclosure Barring Service check being undertaken. References were seen within the staff files were looked at. There were nine staff members working within the care home with previous convictions. We found there were risk assessments in place however, control measures were not seen. We discussed this with the registered manager and regional manager so further improvements could be made to ensure the risk assessments were robust. This was actioned by the registered provider who reviewed all risk assessments in place to ensure they were robust.

We found two people living in the home required oxygen. We found they had a care plan for their use of oxygen but there were no risk assessment for the use and storage in their bedrooms. A risk assessment was immediately written by the nurse in charge and placed within each person's care plan. We checked where an oxygen trolley was for a large oxygen cylinder for one person. It was found within the clinic room and had not been put back in the person's room. We also highlighted to the nurse in charge there was an oxygen tube trailing across the person's floor posing a trip hazard and increasing the risk of tares to the oxygen tube in the event it was ripped. There is health and safety guidance for the use of oxygen and subsequent equipment. The Commission refer to the Health and Safety Executive advice set out in publication reference: NDG459, published 01/2013 Titled "Oxygen Use in the Workplace". This document refers to the responsibility of the employer to reduce the risks of oxygen enrichment in the event of the oxygen hose becoming damaged with a leak and what to do if carers suspect an oxygen leak.

These issues are a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

We found personal evacuation plan [PEEPS] were seen in care plans we checked. The maintenance files were viewed and we found regular checks were being undertaken of fire safety equipment, call bells, bedrails and sensor mats in place for people at risk of falls. We viewed the legionella, gas and electrical certification which were valid. The service had been awarded a five star rating by Environmental Control on their last visit to the care home.

Requires Improvement

Is the service effective?

Our findings

On the last inspection on 18 and 20 April, 26 May, 13, 14, 21 and 22 June 2017 we found not all Mental Capacity Assessments had been updated and not all DOLS authorisation applications had been renewed when they expired. There was a breach of staff training related to training being condensed and aspects of training such as in restraint not being provided. A notice of decision to impose conditions on the provider's registration was served. The provider demonstrated they had met the positive condition which was no longer required.

On this inspection we found improvements had been made and the provider was no longer in breach of Regulation 11 Consent or Regulation 18 staff training but further improvements were needed.

We looked into how effective the care was. One person told us - "I am happy about the general care here." A second person said - "All the staff are good. Happy with the care." A third person told us "Staff are very, very good, will do anything for you." A fourth person told us "Don't have any staff I don't like." We also asked relatives for their views. One relative said, "Happy about the way staff look after [service user]. A second relative said - "Mother receives good care. Staff work under a lot of pressure. Staff get moved about a lot. Good staff can be moved to the middle or top floor. So don't always get the same carers."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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 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.

There was a Mental Capacity 2005 framework seen within the care plans we viewed and best interests processes seen in the records. There was a DOLS tracker for the home and we viewed DOLS applications which had been sent to the Local Authority when appropriate. We found further improvements were needed as the registered manager was unclear if a person had a power of attorney for care and welfare or finances. It was not clearly documented within care plans we viewed when a person had a power of attorney or lasting power of attorney in place. This is important to ensure people are receiving the appropriate support for decisions being made about their care, welfare and finances. We also found some best interests decisions had not been completed for people who lacked mental capacity.

We checked the training and competency checks being undertaken within the care home. We found not all staff were receiving additional training when it had been identified there was a gap in their learning. For example, it was identified that for one staff member they required additional training in dementia care due to the manner in which they spoke to a person living with dementia. Despite this being identified in

September 2017 the staff member had not undertaken their further training at the time of our inspection. The staff member had also not received any additional supervision following the incident in September 2017.

The training coordinator for the home had implemented first aid training for staff. One staff member told us they had completed a three day first aid course to train as a first aider, received training to become a fire marshall and had undertaken a "train the trainer" course to provide training in moving and handling. A dementia specialist had visited the care home to provide training for 27 staff at the time of our inspection and had also undertaken a seminar for relatives of people living with dementia. The trainer had arranged for further dementia training to be provided and had booked 14 places for staff in the care home to attend. There were16 Topics of training that was mandatory and there was a training matrix in place to track which staff members were due to refresh their training with a date.

Agency staff we spoke with told us they had received an induction and were providing care on the same unit each time they were working in the home. Other staff members who worked in the home told us they had received an induction and training. The Care Certificate was being implemented and staff were being supported to complete these national care standards. One staff member told us the dementia training was good and they had received a mixture of training by watching DVD's and interactive classroom training. They also confirmed to us they had attended bi-monthly supervisions.

Most people told us they liked the food they were offered. We found people were being supported to eat and drink and there was a system in place of recording people's nutritional requirements. We observed a lunch time dining experience and observed people being supported appropriately with eating and drinking. We found people who required weekly or monthly weights were being weighed accordingly. People's allergies were being recorded and special dietary requirements. However, we identified three people who had Diabetes type 2 had no care plan in place for staff to know how to support them with their dietary requirements. The chef had not been made aware there were people living in the home with diabetes type 2. Fresh fruit and vegetables were being delivered to the home three days per week but we noted there were no low sugar foods specifically for people with Diabetes type 2. Further improvements were needed to ensure people with diabetes were receiving an appropriate diet for them.

This is a Breach of Regulation 14 Nutritional and Hydration Needs of the Health and Social Care Act Regulation 2008 (Regulated Activities) 2014

We found evidence of healthcare professionals being involved in people's care and referrals were being made for people to receive health care. People's care needs were being assessed according to their wishes within their care plans.

The building design was adapted to include a coffee bar area at reception, a hairdressing salon for people and activities/training room. There were gardens at the rear of the building with a patio area where people enjoyed sitting out if they wished to.

Requires Improvement

Is the service caring?

Our findings

On the last inspection on 18 and 20 April, 26 May, 13, 14, 21 and 22 June 2017 we found people's dignity was not always upheld with an inappropriate use of language seen in care plans. We found other concerns in relation to dignity on this inspection. The provider remained in breach of this regulation Dignity and Respect.

We asked people if they felt cared for. One person said "It is like a top class hotel, nothing could be better than this here." A second person living in the care home told us "Happy here, been here about a year. Some staff are very kind, but a few can be a bit rough". A third person said "Staff are very kind. But they are too busy to talk to me, they can be very busy with a lady who needs a hoist. I feel lonely at times." A fourth person told us "I like the freedom of coming and going as I like here." A fifth person told us - "I don't think I can have a say in what I like or don't like, but I am happy about the care."

A relative told us "{service user} cannot be in better care". A second relative said "Care is outstanding as far as I can see. Staff go way beyond expectation, go the extra mile. They are genuine and they love [service user]." A third relative said – "I can't fault them here".

Not all staff had demonstrated a caring and compassionate manner towards people they were caring for. There had been an incident whereby a staff member had spoken with a person who was living with dementia in an inappropriate manner. We also received concerns from a relative regarding people's dignity not being upheld due to low staffing numbers in the home. One person who had lived in the home for some years had not been supported to celebrate their birthday. The home chef usually bakes birthday cakes for people's birthdays.

These issues are a Breach of Regulation 10 Dignity and Respect of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

There was a calm atmosphere within the home and staff were frequently seen smiling and laughing with people. We observed caring and warm interactions between staff including the registered manager and people who were living at the home. Staff told us how they were motivated to do all they could to support people they were caring for and demonstrated this during our inspection. We observed that people's dignity was upheld. Menus were seen visible on the tables and each table had a table cloth and napkins for people to use. Other people were offered the choice of a napkin being placed over them so as not to discard their clothing. People were offered a second portion if they wished and people were being encouraged to be as independent as possible.

We observed one person being supported by the nurse in charge in an attentive, gentle, calm and compassionate way.

We observed people moving around the care home freely and people were being asked what they would like with their preferences being taken into consideration. Advocacy services were available for people who

required them.

Requires Improvement

Is the service responsive?

Our findings

On the last inspection on 18 and 20 April, 26 May, 13, 14, 21 and 22 June 2017 we found people were not receiving person centred care and the system for managing complaints was not robust enough. On this inspection we found some improvements and the provider was no longer in breach of regulation 9 person centred care but remained in breach of regulation 16 complaints of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We looked into how responsive and person centred the care was for people. We received some concerns from relatives who raised issues related to a lack of opportunity for trips out and activities to provide stimulation. One relative we spoke with told us they felt their relative was not been supported to have trips outside. A second relative told us - "I am very concerned about the lack of stimulation and activities for [service user] who has dementia. Have talked to the staff about taking [service user] out, but were told that [service user] was not interested." We received concerns people were not always being supported to have relationships. This was being investigated by the provider.

There were two leisure and wellness coordinators within the care home to provide activities at the time of our inspection. The home had their own transport but they were limited to accompanying people outside according to the ratio of staff required per person in line with their risk assessment.

The care plans we viewed contained specific information about the person such as where the person was born, names of places important to the person, names of their pets and previous hobbies or occupations. Relatives had input into providing this information when the person first arrived at Prestbury Care Home to live. The Leisure and Wellness staff had ensured this information was included in each person's care plan we viewed. We viewed photographs of people receiving person centred care including visiting places of interest with staff, participating in activities organised by leisure and wellness staff within the home and on a one to one with staff members.

We viewed the leisure and wellness programme and found a weekly programme of activities within the home including a trip out in the mini bus, art therapy group with the Stroke Association, nail and polish, cocktail night, reminiscence time, armchair exercises and resident of the day.

We observed a number of people were receiving visitors. One person's relative was seen in the care home throughout one day of the inspection. Other relatives explained they were greeted warmly by staff when they visited the home.

We viewed the complaints log and viewed the complaints file. We found there was a complaints form being used. The information was incomplete with no follow-up actions specified of how they were going to prevent the same problem from arising again. This did not demonstrate the registered manager or provider were doing all they could to learn from their mistakes with lessons learnt. We asked the regional manager and the registered manager to look into a specific complaint regarding end of life care, a copy of which had been sent to the Commission but we were informed by the registered manager and regional manager it had

not been received by the provider. For the complaints we viewed there were no contemporaneous records of the details of the actions undertaken or copies of letters to the complainant in response to the complaint. Some complaints seen were in relation to how staff had responded to a person whilst delivering care. We discussed this with the registered manager as the nature of the complaint amounted to a safeguarding concern.

This is a breach of Regulation 16 Complaints of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

There was one person receiving end of life care at the time of our inspection. We asked a staff member for the person's care plan and we were provided with a care plan which contained basic information and was not sufficient. This was raised with the registered manager who confirmed there was a second care plan which we were then provided with. This contained additional information but it was unclear if both care plans were being referred to by staff as one of the files had not been located in the clinic room and was later obtained by the registered manager.

Inadequate

Is the service well-led?

Our findings

On the last inspection on 18 and 20 April, 26 May, 13, 14, 21 and 22 June 2017 we found a breach of regulation 17 Governance due to the quality assurance systems not being robust. Statutory Notifications were also not always being submitted to us when appropriate. On this inspection the registered manager and provider remained in breach of regulation 17 Good Governance due to repeated breaches of the regulations and systems not being robust enough.

We asked people what they thought about the management within the care home. One person told us - "I don't know who the manager is. If I am concerned about anything, I would go to [staff member] the senior carer." A second person said - "I think the manager is [name of the manager]. They call round." A relative said - "Home manager is very good, I have seen them about".

We found residents meetings were being held within the care home. We viewed the minutes of the residents meeting dated 30 November 2017. The minutes identified some of the issues at that time for people. For example, the minutes stated – "there were some concerns raised with regard to staff leaving." The registered manager's response was "It was explained this will always happen and more so within the care industry, when individuals will want to progress perhaps. Prestbury House does all it can to ensure valued members of the team are well supported and encouraged to remain within the employment of the organisation". This response did not provide any substantive information in relation to the number of staff vacancies and how the registered manager was managing to fill the vacancies in the short term or longer term. There were other items raised by people according to the minutes with limited information provided in response. Therefore, we questioned the transparency of the registered manager in not providing people with enough information to reassure them how they were driving improvements forwards.

We also viewed the Clinical Governance Meeting minutes dated 15 November 2017. This was the first of these meetings arranged by the registered manager. The minutes noted various areas for improvements identified by the registered manager including people always being awarded their dignity when being spoken with by staff, health and safety and maintaining records securely. Although this demonstrated areas for improvement it did not confirm what actions were going to be taken with dates when they were to be completed by with areas of responsibility defined.

Although training had improved overall since the last inspection, there were areas for further improvements needed. The registered manager had not ensured staff who were identified to need additional training had received the training in a timely manner. Risk assessments for staff with previous convictions were not robust enough and restrictions on staff practices were not being managed with control measures in place. We found information of concern about a staff member's practice which had been previously identified by the registered manager. Despite the registered manager being aware of this there were no control measures in place to either provide additional supervision or competency checks. Not all that could be done was being actioned by the registered manager to reduce the risk of further issues.

We raised concerns regarding the registered manager's handling and management of complaints on this

inspection. We found some complaints logged were safeguarding concerns and had not been managed appropriately. Another complaint sent to the Commission could not be found logged in the complaints file on inspection.

We questioned the registered manager as to whether a staff member had received supervision following an incident in the home involving the staff member. The registered manager told us they had undertaken supervision following the incident. When we asked for evidence of this it could not be found. We therefore, questioned the reliability and transparency of the registered manager.

We were concerned the systems of communication within the care home were not always robust. Pertinent information in relation to people who were diabetic had not been communicated to the chef in the home. We also found concerns related to how some information was being communicated within the residents meeting minutes. We also received some concerns from a relative who was concerned they had passed on important information in relation to their relative who lived in the care home but found each time they visited it had not been passed onto the staff on duty.

During this inspection we identified concerns regarding staffing levels. When we asked the registered manager they confirmed to us they considered staffing levels not to be a concern. The registered manager was unaware how to audit the call bell response times when we asked for this information. We were therefore, concerned the registered manager was assessing staffing levels according to dependency scores in isolation from other means of assessing an appropriate staff to resident ratio.

All of the requirements of the action plan submitted to the Commission following the last inspection had not been met. There were continued breaches of the regulations set out in this report which were attributable to the lack of leadership and robust quality assurance systems to drive improvements across the home.

These issues are a breach of Regulation 17 Good Governance of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

Daily morning meetings were being held in the care home for any concerns to be raised by staff. Resident of the Day had also been implemented by the registered manager. A DBS tracker had been set up by the regional manager who had recently begun to have input into the care home. The regional manager began working in the care home from approximately November 2017 and had begun to expedite the improvements required to meet all of the regulations of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and respect were not always being upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not always been identified in order to mitigate them to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Not all safeguarding concerns had been logged in the safeguarding tracker or were dealt with as a safeguarding concern.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We found people's dietary requirements were not always being considered to always ensure they were receiving appropriate nutrition to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Receiving and acting on complaints The records of how complaints were being managed were not robust enough.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance systems had not identified all of the concerns highlighted during the inspection and were not robust enough.