Chasewood Care Limited

Chasewood Care Limited

Inspection report

Chasewood Lodge
McDonnell Drive, Exhall
Coventry
Warwickshire
CV7 9GA

Tel: 02476644320

Date of inspection visit:
17 April 2018
19 April 2018
20 April 2018
27 April 2018

Date of publication:
20 August 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The first day of our inspection visit was on 17 April 2108 and was unannounced. We told the provider a pharmacy inspector would carry out an inspection of medicines administration and management on 19 April 2018 and two inspectors would visit again on 20 April 2018. We made a fourth visit to the service on 27 April 2018, to follow up on areas that required clarification.

Chasewood Care Ltd 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 is registered to accommodate 107 older people in six units across two floors of one building. The care home provides the service for older people, who may live with dementia. Fifty seven people lived at the home at the time of our inspection visit.

We previously found the provider was in breach of the Regulations in safe and well-led and rated the service requires improvement overall. We asked the provider to complete an action plan to show what they would do, and by when, to improve the key questions of safe and well-led, to at least good. The provider sent us their action plan in February 2018 and we looked at their action plan as part of this inspection. We found the provider had not taken the actions they said they would take to improve the service, in line with their action plan. The provider had not made the improvements in the quality of the service required to meet the Regulations and continued to be in breach of the same Regulations and in breach of other Regulations and of the conditions of their registration.

The provider had not sent us the copies of their audit reports by the 28 of each month, as required by the additional condition of registration we imposed in December 2016.

There was not a registered manager in post. The previous registered manager had retired from the service in December 2016. 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 manager had worked at the service since June 2017. They had not registered with us. There had not been a registered manager in post for fifteen months.

We found systematic and widespread failings in the oversight, monitoring and management of the service, which meant people did not always receive safe care. There was not an effective system to identify and manage risks to people's safety in how the premises were used. The provider's fire risk assessment had not been reviewed since January 2017 and contained out of date information. There were no signs or reference points to support an evacuation in an emergency or to enable people, staff or visitors to find their way around the building. There was not enough mobility equipment to ensure people were supported safely when they needed support.

The system and process of assessing individual risks to people's health and safety, through personalised

care planning, was not effective. People's care plans did not give staff the guidance they needed to support people safely and minimise their personal risks. People's care plans were not updated accurately when their needs and abilities changed, which put them at risk of poor care that did not meet their needs.

Improvements were required in the management and administration of medicines to ensure people received their medicines when they needed them and in accordance with their prescriptions.

The oversight, monitoring and auditing of the service failed to identifying risks, trends or patterns that would have enabled to them make changes to minimise the risks of a re-occurrence and make improvements to the quality of service. The provider had not ensured that all allegations of abuse were referred to the local safeguarding authority and had failed to notify us when they did make such referrals. The provider had not always notified us when a person died and had failed to notify us of other important events at the service. Failures to notify us of serious injuries and safeguarding incidents, had prevented us from monitoring the service effectively.

Records related to people's care, support and treatment were incomplete or not up to date. There was not an effective or auditable system of sharing important information about people's needs, any incidents they were involved in or any changes to their abilities. Care plans contained insufficient detail about people's personal histories and interests to support staff to deliver person centred care.

The provider did not operate an effective complaints handling system that would have enabled them to identify trends or areas of risk that they could have addressed to improve people's experience of the service.

People felt staff had the skills and experience to care for and support them, but staff did not always receive the training they needed to support people effectively. Some staff did not recognise that the way they supported a person who presented behaviour that challenged was uncaring and could amount to a deprivation of the person's liberty. Staff had variable understanding of the meaning of dignity, respect and promoting independence. People had limited opportunities to engage in meaningful activities that they enjoyed.

People were not consistently offered a choice of meals and the provider had not ensured there were sufficient supplies to provide the meals according to their planned menus. The provider had failed to ensure that people were enabled to find their way around independently, due to a lack of directional signs or points of reference along the corridors.

The provider, manager and staff did not work together to improve the quality of the service. People's or relatives' views of the service not sought, heard or responded to. Staff experienced a lack of communication, inconsistent direction and guidance and were not supported to be instrumental in making the required improvements. The provider had not met with the staff to hear their concerns or suggestions for improving the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures. This is the second time the service has been in special measures since November 2015. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks related to the safe use of the premises had still not been identified or managed. There continued to be risks to people's safety in the event of an emergency. Risks related to people's individual safety and health were still not identified in their care plans and were not always mitigated by staff's actions. There was still not enough mobility equipment to ensure people were supported to mobilise safely when they needed to. People were not always referred to the local safeguarding team when they should have been, to ensure they were not at risk of abuse. Medicines were not always administered in line with people's prescriptions and improvements were required in the safe management of medicines. New staff continued to be recruited safely, to ensure they were suitable to work at the service.

Is the service effective?

Inadequate

The service was not effective.

Care plans did not include sufficient guidance for staff to support people effectively. Staff had not received the relevant training to support people's individual needs effectively. Some staff did not demonstrate they understood the principles of the Mental Capacity Act 2005. People were still not supported to find their way around the home because there were no directional signs or points of reference along the corridors. People were not consistently offered a choice of meals and the provider had not ensured there were sufficient supplied to deliver their planned menus. Staff did not always share information effectively about people's moods, appetites and behaviour.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff still did not consistently demonstrate the same level of understanding and behaviour in caring for people, particularly for those who lived with complex needs. Some staff did not promote people's independence or recognise their right to privacy. Some staff did not treat people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not responsive.

The provider did not have an effective complaints handling system that enabled them to identify, trends or areas of risk that they could have addressed. People's care plans were regularly reviewed, but were not updated effectively when their needs changed. People's care plans did not contain sufficient information about their personal history and interests to support staff to know them well. People were not offered sufficient opportunities to engage in meaningful occupation to stimulate them.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not met two conditions of their registration, to have a registered manager and to regularly send us copies of their audit reports. The provider had not made the required improvements since our previous inspection and remained in breach of the regulations. The provider had not taken the actions they said they would take to improve the service. The provider had still not implemented an effective system of audits that could identify risks, trends and patterns that would drive changes in how the service was managed. The provider had not notified us of important events at the service. Staff did not feel supported or encouraged to improve their skills or consider their career development. Staff were not well-led, managed or supported.

Chasewood Care Limited

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.

Chasewood Care Limited is a residential care home. People in care homes receive accommodation and nursing or personal care as a 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 up to 107 older people, in six units, on two floors, some of whom live with dementia. At the time of our inspection, 50 people were living at the home permanently and seven people were living at the home temporarily after a stay in hospital.

This was a comprehensive inspection, prompted in part, because we received information of concern from a whistle-blower and from a healthcare professional about the leadership and governance of the home and because of the history of the service. We brought our scheduled inspection forward to check whether there was any substance to the whistleblowing information; whether the provider had taken the improvement actions they said they would take; and to check how and when they intended to meet the conditions of their registration. We reviewed the information we held about the service and information that was shared with us by the whistle-blower and by the local commissioners of care and healthcare professionals.

Following our inspection in November 2017, the service had been rated as 'requires improvement' in well-led and overall. The provider had sent us an action plan setting out how they planned to improve. The provider has been in breach of two conditions of their registration since May 2017. There was not a registered manager in post, and there had not been a registered manager since December 2016. At our inspection in April 2016, the provider was in continued breach of Regulation 17, so we imposed an additional condition on their registration in December 2016. The additional condition requires the provider to send us copies of their audit reports each month. They had not complied with this condition effectively since May 2017.

The inspection visit took place over four days. Three inspectors and an expert by experience visited the

service on 17 April 2018. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of dementia care service. This visit was unannounced. We told the provider we would come back on 19 and 20 April 2018. A pharmacy inspector visited the service on 19 April 2018 and two inspectors visited the service on 20 April 2018. One inspector visited the service on 27 April 2018, and this visit was unannounced.

We did not ask the provider to complete a provider information return (PIR) before our inspection, because this was a responsive inspection. The 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.

During our inspection visit, we spoke with three people who used the service and four relatives about what was like to live at the home. We spoke with a visiting healthcare professional; the provider, a director of the service, the manager and 13 staff, including two deputy managers and seven care staff, the head of kitchen and housekeeping, the kitchen assistant and two domestic staff.

We reviewed five people's care plans and looked at elements of another five people's care records. We reviewed ten people's medicines administration records and other records associated with medicines administration. We reviewed six staff recruitment records and records of the checks the provider and management team made to assure themselves people received a quality service. The provider sent us copies of their audit reports for January, February and March 2018, during this inspection.

Inadequate

Is the service safe?

Our findings

At our inspection of November 2017, we found the provider was in breach of the regulation for safe care and treatment. Improvements were needed to the premises and how the provider mitigated risks to people's individual safety. In February 2018, the provider sent us a report of actions they planned to take to improve safety within the home. However, the action the provider had taken had not been effective they remain in breach of Regulation 12, safe care and treatment.

People's care plans were still not updated effectively when their needs changed and the guidance for staff did not reflect the care and support people needed. The provider had still not conducted a risk assessment, with control measures and actions to minimise risks related to their refurbishment programme.

On the first day of this inspection, we saw the lockable gate fitted previously to stop access to an unsupervised part of the building, had been removed and one person was in this area without supervision. The provider knew this person was at risk of hurting themselves when out of sight and sound of staff, but had not made sure the person was unable to enter alone. When we alerted staff to the fact that the person was walking unobserved in this area, staff persuaded the person to return to a communal area where there were staff. The provider reinstalled the lockable gate.

Improvements had not been made in the system for reporting maintenance issues to ensure repairs were undertaken promptly and effectively. Staff told us there were problems with the hot water supply in the shared bath and shower rooms, 'for months' and intermittent problems with the lights in the shared bathrooms and toilets, but no one knew what was causing the problems or when they would be fixed. The provider's maintenance log for March 2018 showed that staff had asked the provider to fix the problem of hot water running out five times. A date for when the issues would be investigated, or when they would be resolved, was not known. The manager told us there continued to be a problem of the hot water 'running out' during this inspection.

There was a risk people would not have been safely evacuated in the event of an emergency. The fire risk assessment had not been reviewed since January 2017, when different people lived at the service and before the provider's refurbishment programme had started. There was no record to show when a fire drill was last completed and staff training records did not identify whether staff had received any training in fire drills. People who used the service had personal emergency evacuation plans (PEEPs), but these were not all up to date. Some PEEPs said that people occupied bedrooms they had moved out of. The six individual units of the home had been renamed during the refurbishment, but the PEEPs did not all indicate the previous or current name of the unit people slept in. The emergency 'grab bag' did not contain an up to date register of everyone who lived at the service, including their needs for assistance with mobility, to support a safe evacuation of the building in an emergency.

Risk assessments and care plans were not updated so staff did not always have sufficient information to respond to people's health needs. Staff had not updated people's paper based records effectively or at the appropriate time, and we found examples where risks to people's individual health and safety had not been

mitigated. For example, one person had a fall due to a seizure. The person's care plan failed to record the person had a seizure and it had not been updated to include additional information for staff to know what signs to look out for and the type of care to provide. The manager told us they should have checked to make sure the person's care plan was updated, but said they had not, because of 'time constraints'. Senior staff were aware that people's care plans needed more detailed guidance and instruction to ensure staff knew how to minimise risks to people's health and safety.

A senior member of care staff told us how they made sure the air flow mattresses were working correctly and what they did to get them serviced, however, they told us they did not check the air flow mattresses were set according to the person's weight. The care plans for the three people we saw were at risk of sore skin, did not record the pressure their mattresses should be set at, and only one of the three plans explained that the air flow mattress had been prescribed for the person. We saw all three people's mattresses were not set at a pressure that was appropriate to their last recorded weight. There was a risk their mattresses would not distribute their weight evenly and minimise the risks of skin damage.

In the absence of clear instructions, staff made their own decisions to minimise risks to people's safety, which resulted in inconsistent support by staff. One person's care plan, said they should have a crash mat beside their bed to reduce the risk of injury if they fell from their bed, plus two hourly checks when they were in bed. One member of staff told us they had stopped using a crash mat, and instead put a sensor mat by the person's bed, to alert staff if the person got out of bed. There was not a sensor mat or crash mat in the person's room. Another member of staff told us the sensor mat had broken two weeks ago, but had not yet been repaired or replaced. The member of staff told us they currently minimised risks to the person of falling from their bed and sustaining an injury by checking on them every 30 minutes. Records showed that night staff continued to check the person every two hours, as per the care plan, not every 30 minutes, as described by the member of staff. Night staff had not identified that the crash mat was not in place. No staff had recorded that the crash mat had been replaced by a sensor mat, or that the sensor mat was broken or that they had changed how they mitigated risks to the person by half hourly checks.

One person was seen with bruising on their face. Staff were not able to tell us how or when the bruising had been sustained and only knew it was 'unwitnessed'. There was a body map in the person's care plan which was marked, "Bruised head, 14/4/18, no witness". There was no mention of the incident or when staff first became aware of the bruises in the person's daily records or in the staff handover notes for the 14 April 2018. Staff had not updated the person's risk assessment or care plan, and the person continued to walk around alone as before. There was insufficient recognition of the person's individual risks of another unwitnessed injury and the person had not been referred to the local safeguarding authority. The person's 'acute care' plan, written in June 2016, noted that they liked to, "Go into unattended bags, cupboards, other residents' rooms and the store cupboard" and "Has started eating unsafe things". The acute care plan had been reviewed 22 times. Each review was marked, "No changes", despite a significant change in the person's environment in February 2018. The care plan did not include a risk assessment related to the change in the person's environment, or to the change in the people they lived with. The risks to this person of walking around their home independently were known, but there was no updated risk assessment related to the person's personal safety or measures to minimise the risks.

This was a continued breach of Regulation 12 (2)(a)(b) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment in relation to assessing risks and taking reasonable measures to mitigate risks to the health and safety of service users.

There was not enough mobility equipment to support people safely and according to their assessed needs. A member of staff member told us the provider had bought four new wheelchairs, but they were not

currently available. The member of staff told us two of the new wheelchairs had 'vanished'. They said they still had some older wheelchairs in good repair, but the footplates had 'vanished'. This impacted on people's ability to receive care in a timely way as there were insufficient chairs and we saw people had to wait for someone to use a chair before them. Staff told us the provider and manager knew there was not enough equipment to meet everyone's needs.

This was a breach of Regulation 12(2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment in relation to supplies of equipment and medicines.

The provider had not ensured the proper and safe management and administration of medicines. People had mixed views about whether they received their medicines when they needed them. Whilst some people told us they were happy, one person told us they sometimes did not receive an early morning medicine at the time they should have it and often received their bed time medicines about 11:30pm, but they were used to taking them at 9:30pm. People's medicines administration records (MAR) showed that medicines were not always administered in line with their prescriptions, but staff had not explained why not. The amount of medicines in stock did not always match the amount that should have been in stock, if people's MARs had been completed accurately. For example, across five different MAR charts, the amount of medicines that were recorded as 'given' and 'remaining' did not match the actual amount in stock in six instances.

There was a risk people were given 'as required' medicines inconsistently or inappropriately as there were no protocols available. Records showed they were often administered without an explanation. Between 1 and 17 April 2018, calming medicines had been administered 17 times to four different people, but there were not always matching records to evidence how each would benefit from calming medicines. Two people's records showed they were given their medicines in food or drinks without their knowledge. There was no documented evidence to demonstrate the decision to administer medicines this way was taken in the person's best interests by a multidisciplinary team. There was no documented evidence to demonstrate the provider had obtained the advice of a pharmacist to ensure it was safe to give the medicines in food or drinks.

Medicines were not always stored appropriately or safely. We found an unmarked box of medicines that were no longer required that should have been kept in a locked medicines store, while awaiting return to the pharmacy. In one lockable cabinet that was intended to store controlled drugs, staff had stored other items, including cigarettes and some jewellery in an envelope. There was a risk that medicines could be accessed by staff who were not trained in safe medicines management.

Fridge temperatures were not recorded in line with the guidance for safe management of medicines. Readings taken on the day of the inspection showed the maximum refrigerator temperature was above the specified maximum temperature, but was being used to store a temperature-sensitive medicine. The provider could not be confident that the medicine had retained its effectiveness.

The provider's electronic medicines' recording system was not able to evidence when strong medicines called 'controlled drugs', had been received, administered or returned to the pharmacy for destruction. The provider's medicines management system was not able to demonstrate that analgesic skin patches were being applied in accordance with the manufacturer's guidance, which meant people were at risk of having patches applied to the same part of their body too frequently, and were at risk of experiencing unnecessary side effects.

This was a breach of Regulation 12(2)(g) of the HSCA 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

Previously we had found the manager had notified us they made a referral to the local safeguarding authority, but after it had been substantiated and action taken. They had not realised they needed to notify us as soon as they made a referral, without waiting for the outcome of the safeguarding team's investigation. The provider had not established or operated effective systems or processes to identify incidents of abuse. Staff had training in safeguarding, but the provider had not ensured that incidents classified as safeguarding were referred to the local safeguarding team when needed and notified to us. Records showed an incident had occurred in December 2017, when one person had been found kicking another person's legs. The record stated that a body map had been completed for the person who was kicked, to show where they were kicked and the marks to their skin. However, there was no record to show they had been referred to the safeguarding team as 'at risk of abuse by another service user'. We were not notified that a referral had been made.

The provider had not ensured the manager understood and followed the safeguarding process. A relative told us they had made a complaint to the manager to investigate about how their relation was supported. The manager told us they were investigating these allegations but they had not recognised that the allegations constituted allegations of abuse and referred the local authority safeguarding team and we should have been notified of the referrals. After we pointed this out to the manager, they referred the matter to the safeguarding team.

This was a breach of Regulation 13 of the HSCA 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

The provider had not learned lessons from accidents and incidents and had not made the improvements identified as 'required' from previous inspections. There was not a list available of all the accidents and incidents that had happened since our last inspection, to enable the provider to analyse accidents and take action to minimise the risks of a reoccurrence. The provider had not improved the quality, accuracy or effectiveness of the paper based risk assessments and care plans and a new electronic care planning system the provider told us would deliver the required improvements, had not implemented.

People and relatives told us they felt safe at the home and said they felt there were enough staff to meet their needs because they did not have to wait long for support. People said, "I can lock my door on the inside and I do sometimes" and "I'm safe, the care is good." A relative said, "[Name] is a lot safer here than at home." One person told us staff came to check they were 'alright', when the alarm went off and came promptly if they rang the call bell.

Staff told us there were enough staff most of the time, it could be a 'struggle' if staff called in sick at the last moment, but that the deputy managers would work 'hands-on' to support them. A member of staff said, "We will move ourselves around as needs be if we are short anywhere. There is always a member of staff with people all the time." At the time of this inspection, there were enough staff on duty to support people safely. At our last inspection the provider had relied on an out-dated system had not used a 'needs dependency' tool to identify and aggregate everyone's needs for support, to enable them to decide how many staff should be on duty for each shift. The manager told us they were working on a dependency needs analysis tool with the provider.

The provider's infection prevention and control measures were effective. We saw the home was clean and people's clothes and laundry were well organised and managed effectively, to minimise the risks of infection. The provider had delegated the responsibility for preventing and controlling the risks of infection to a senior member of staff, who worked as the head of kitchen and housekeeping.

New staff continued to be recruited safely. Records showed the provider had continued to follow the guidance for safe recruitment of staff. The recruitment process included making all the pre-employment checks required by the regulations, to ensure staff were suitable to deliver personal care.

Inadequate

Is the service effective?

Our findings

At our previous inspection in November 2017, the service was rated requires improvement. The required improvements had not been made at the time of this inspection. People's care plans did not contain sufficient guidance for staff to ensure people were supported consistently and effectively. Staff did not receive appropriate training to mitigate risks to people's well-being. Some people received inconsistent support that did not meet their needs. The service is rated inadequate in effective.

Improvements were required in assessing the care, treatment and support required to ensure it is delivered in line with current legislation, standards and evidence-based and in staff training to ensure people were supported effectively .

People's care plans did not include sufficient guidance for staff which was personalised to ensure they were supported consistently and effectively. This was of particular concern, where people become agitated, had specific health conditions or were known to display a behaviour that challenged others. Care plans should contain guidance and information in sufficient detail, to staff to be able to offer care in a safe and consistent way. For example, one person who lived with epilepsy had an 'epilepsy care plan' marked, "There is some information about epilepsy at the back of this care plan." This was not tailored to the person as an individual. It did not explain the signs for staff to be aware of that might indicate the person was about to experience a seizure, or the individual impact of a seizure on the person.

Another person was known to display behaviour that challenged due to their health condition. An incident report of December 2017, recorded that the person had thrown a cup on the floor, "As they were becoming agitated." The consequence of this incident, as recorded by staff, was, "[Name] was transferred into their bedroom, to calm themselves down." The person's resting and sleeping plan was marked, "[Name] likes to rest in the lounge where (they) are safe." It did not say they liked to rest in their bedroom during the day or if agitated.

Risks to people's safety were not effectively mitigated by training for staff. Staff were not adequately trained and many did not have the skills, knowledge and competence that are required to support people effectively. Records showed staff had not received the necessary training or guidance to support people effectively who presented behaviour that could challenge others. There was no record of staff attending training in supporting people with epilepsy.

The lack of clear guidance and training for staff resulted in staff's variable skills in supporting people who presented behaviour that challenged others. One person was trying to open a locked gate and could not be dissuaded by the first member of staff, or by the manager. A third member of staff needed to be called, to encourage the person to walk away with them. The manager told us this person regularly presented behaviour that challenged others and that it could take up to four staff to support the person.

An incident record showed this person had physically challenged another person in December 2017, but their personal care plan did not explain how staff should intervene in this instance and did not reflect the

risks they posed to others. Four incident reports for this person demonstrated staff took different approaches to support the person, with variable results. Records showed staff's strategies for supporting the person were inconsistent and with varied outcomes. On four different occasions, staff recorded they had, "Monitored and followed" the person; "Required four care staff to assist"; "Decided to call another staff, which really helped"; and "Seemed to get worse and this went on for a good hour." There was no evidence that staff had tried to identify the cause of the person's agitation or knew of any effective distraction techniques.

Staff did not record events prior to incidents or what else was happening at the time that might have identified the cause of the person's agitation. When staff decided to leave one person in their bedroom to 'calm down', they had not demonstrated understanding of the person and there was no evidence that staff had tried to identify the cause of the person's agitation. This person was unable to mobilise independently and was reliant on staff to transfer them from their bedroom to the communal areas.

People's daily records and staff handover records did not always include the information staff needed to adapt their approach to changes in people's moods, behaviours or abilities. Handover between staff leaving and starting work was supposed to take place, and to be recorded, three times a day. There were only three handover records available for the unit 'Copperfield' for the week before our inspection. The records consisted of handover notes at the end of one day, one set of night staff's 'two hourly checks' and one page of A4 paper with a list of people's names. The incident of one person sustaining 'unwitnessed bruising' on 14 April 2018, was not mentioned in the person's daily records or the handover notes. There was not an accident or incident report in the person's file, to demonstrate that staff reported accidents and incidents effectively. A member of staff told us the incident had 'probably not been reported', because it was unwitnessed, that is, staff did not see when or how it happened, so they did not report it.

This was a continued breach of Regulation 12 (2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment in relation to assessing risks and taking reasonable measures to mitigate risks to the health and safety of service users.

Improvements were required in staff's understanding of the principles of the Mental Capacity Act (MCA) 20015. Staff had not recognised that their response to a person presenting behaviour that challenged was not in accordance with the principles of the MCA. Their action of taking a person to their bedroom when they were unable to mobilise independently, might not be in the person's best interests and might be seen as a deprivation of the person's liberty. In the absence of clear guidance in the person's care plan, and the lack of training in effective distraction techniques, staff had not responded or supported the person in the least restrictive way.

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). The manager understood their responsibilities under the Act. Where restrictions on people's liberty had been identified, the appropriate applications had been submitted to the authorising authority.

People who were able to express themselves verbally had a better experience of being supported to make their own decisions. People told us, "There is plenty of opportunity to do what I want, no restrictions", "They

(staff) understand how I want to do things" and "I never had to do anything I didn't want to do. They don't dish out orders." They said they thought staff had sufficient skills and experience to support them in a way that met their individual needs. Care staff's induction included shadowing experienced staff and training. New staff who had not worked in care previously had training in the fundamental standards of care, as set out in the Care Certificate. Staff attended training in subjects that reflected most people's needs, such as moving and handling, food hygiene and dementia awareness.

The provider had not ensured they met people's individual needs through the adaptation and decoration of the service. The physical environment was not decorated to a consistent standard to meet people's needs. The manager told us improvements in supporting people to orientate and find their way around the home were in progress. A member of staff told us they had been shown round the home during their induction and said, "That confused me a little bit, because there are no signs." The management team had decided to rename all six units, and different staff referred to the units sometimes by their old names and sometimes by their new names, but only one handmade sign was displayed in the corridor on the ground floor. The new name of the unit was not displayed in a colour or style that was easy for people to read in line with the best practice guidance for people who live with dementia and complex needs. The lack of signage was not conducive to an effective evacuation of the home in an emergency.

Improvements were required in how people were supported to maintain their dietary needs and enjoy their meals. People's mealtime experience was variable and some people were not offered choice of meals. People who required special diets were not always offered a choice. People's experience varied on where they ate their meals, which staff were on duty and whether some food items they wanted were available. Some people told us they were well supported and got a choice. However, another person told us their meals were served pre-plated and they did not have a choice of vegetables. They told us they told us they had been 'given' fish in breadcrumbs with gravy and cabbage with their curry, which they had not wanted. They told us their meals were sometimes cold when they were served. We found meals were despatched from the kitchen at the right temperature, but if more people needed assistance to eat than the number of staff available to support them, some people's meals went cold while they waited to be served.

A list of people's dietary needs which included people's names, room number, any swallowing or chewing difficulties, specific dietary needs and any allergies and preferences, was shared with the head of kitchen. The head of kitchen told us the folder was regularly updated to reflect people's current needs. They were confident that care staff would let them know immediately if they did not prepare meals to suit people's dietary needs. One person's care plan showed they required a specific diet that included restrictions on the ingredients they could eat. This person's hot lunchtime meals were prepared in accordance with their dietary needs, but only one hot meal was prepared for them and they did not have a choice.

People's weight monitoring records showed they were supported to eat and drink enough to maintain a nourishing diet, however, the provider had made changes to the how food was ordered and delivered, which had resulted in insufficient supplies to deliver the planned tea-time menus and to provide snacks of people's choice. People told us they were disappointed when items on the tea time menu, such as ice cream, custard and tinned fruit, were not available. On the first day of our inspection, we found there were no biscuits or crisps and only 20 slices of cake available for 50 people's snacks for two days. The provider had not ensured there were sufficient food supplies to deliver the planned menus or a choice of snacks.

People who were able to express themselves verbally told us they were supported to access healthcare services to maintain their health. People told us, "The doctor comes on a Wednesday. You have to book in. I've had an X-ray and am waiting for the results" and "The chiropodist and optician come. Staff can arrange one." Relatives told us they were confident staff would call for a GP or ambulance service when their

relation's health needs changed.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in November 2017, we found that some people with more complex needs did not experience the same level of caring that other people told us they experienced. At this inspection we found staff's understanding and practice was still variable. The provider had not proactively maintained effective oversight of staff's practice to ensure all staff supported people with kindness and respect.

We found inconsistency in the way staff demonstrated a caring response to people. People who were able to express themselves verbally told us they felt well-cared for. They told us staff were, "Friendly" and "Very understanding and caring." People said, "We talk all the time, it's like a family" and "The empathy and compassion is great." Relatives told us, "Staff are lovely" and "I think they talk very kindly to [Name] and [Name] gets on very well with them." The head of kitchen told us they were in their job, "For the people (who live here). I love them like family."

We saw some individual caring moments that showed some staff understood how people's complex needs impacted them individually. When one person was confused about the date, a member of staff took a calendar down and showed it to the person, which gave the person a visual prompt for the date and month. Some staff demonstrated thoughtfulness in including people in decisions. We heard a member of staff ask, "Are you alright if I open the window [Name]? Tell me when it gets cold and I will close it again". People in the communal areas appeared to be comfortable and at ease with staff. People who were able to mobilise independently walked around the home when they wished. People were offered a cup of tea whichever lounge they went into and were invited to join in with whatever was happening in the lounge at the time.

However, people with more complex needs were not consistently supported by caring and compassionate staff and not all staff demonstrated compassion for people. When people presented behaviour that challenged others, care staff did not always demonstrate understanding and did not try to identify the cause of the person's agitation. Records showed that staff had twice 'left' or 'taken' a person to their room, "To calm down", when they presented behaviour that challenged others, even though the person's care plan said they liked to spend time in the lounge.

Not all staff demonstrated the same level of interest in people's wellbeing or understanding of their individual concerns. In the care plan for a person with complex needs we read that the person had an interest in watches and liked to talk about them. We had spoken with this person at a previous inspection and had noted how animated the person became when discussing watches. Staff told us the person's relative had brought a watch for them, but said they were, "Not sure where it has gone." Staff knew the loss of the watch caused the person to be distressed, but did not explain what action had been taken to look for the watch or to obtain a replacement for them.

Staff did not consistently treat people with dignity and respect. Most people who were able to express themselves verbally told us staff listened to them in discussions about how they wanted to be supported and promoted their independence. They told us staff treated them with dignity and respect. One person said, "It's very dignified I don't have any concerns." The relatives we spoke with all felt their relation was

respected and encouraged to maintain their independence. A relative told us, "When they give [Name] a shower they put soap in their hand and let them wash themselves."

However, people with complex needs did not always experience the same level of respect and dignity. One person was in bed when staff took them their lunch. Staff recognised the person needed to be supported to move into a more suitable position to eat their meal safely. However, the staff did not close the bedroom door before pulling the person's bedclothes back to support them to reposition. This compromised the person's dignity as they were wearing a night dress.

One person who was able to express themselves verbally told us they did not always feel respected, due to their dependence for physical support to mobilise. On both days that we spoke with this person in their own room, a member of staff opened the door without knocking and without checking whether the person was in the room, which was not respectful of the person's right to privacy.

The person told us they had a lockable drawer in their room, but no key. We had raised this issue with the provider during our inspection in December 2016. The provider had said they would make sure everyone had a lockable drawer and a key, but they had not ensured this facility was maintained in every bedroom.

The person told us about a number of events that they felt had compromised their dignity and left them feeling dependent on staff. Their concerns included that staff did not ensure their continence aid was empty before they went to bed at night, that staff had 'blocked' their access to the en-suite wash room with a mat, so they were unable to clean their teeth after breakfast and that staff had failed to remove a broken item from their room. The person said they would like us to share their concerns with the manager in the form of a complaint on their behalf. The manager told us they would investigate these and the other concerns the person had raised.

Requires Improvement

Is the service responsive?

Our findings

During our inspections in December 2016 and in November 2017, we had identified that improvements were required in obtaining and using information about people's previous lives and interests. This information is used to ensure staff are able to respond to people appropriately and that people are supported to maintain their preferred routines. We found there was little written guidance in people's care plans to enable staff to proactively encourage people to maintain their interests in relation to their previous lives or careers.

The provider did not have an effective system that enabled them to identify, receive, record, handle or respond to complaints. They were not able to show us a log of all the complaints they had received since our previous inspection. They had not monitored complaints to identify trends or areas of risk that they could have addressed.

One person told us they had made a complaint about several issues, but had not received a satisfactory response. Their complaints included 'a broken toilet seat being left in their en-suite bathroom' and 'a new continence aid being taken from its box by person's unknown who had left the empty box in its place'. They told us they had made these complaints before our inspection, but nothing had been done about them. We saw the broken toilet seat was still in their bathroom cabinet, alongside an empty continence aid box. With the person's permission, we raised these and their other complaints with the manager during our inspection.

Through our review of management records, we knew of a complaint by a relative that had alleged poor moving and handling practice by staff. The manager told us they had investigated the complaint itself, but there was no documentary evidence to show the provider was aware of the complaint, whether the complaint was substantiated or whether the provider had addressed any identified underlying cause of the complaint.

This was a breach of Regulation 16 of the HSCA 2008 (Regulated Activities) Regulations 2014: Receiving and acting on complaints.
In November 2017, the manager had told us staff's acquired knowledge of people had not been added to the paper care plans, because the electronic care plans were due to be implemented from December 2017. This was where the provider planned to record staff's knowledge, to make sure it was available to all staff.

By the time of this inspection the provider had not taken the action they said they would take, that is, to improve the guidance for staff to enable them to understand people's individual motivations and preferred routines. People's care plans were regularly marked as 'reviewed', but they had not been updated. A senior member of staff agreed that people's care plans did not reflect their individual needs. The said care plans were not written, "In the detail they need. They could be more person-centred." People's care plans did not guide staff to respond effectively, because their care plans were still not updated with staff's knowledge of the person. For example, a member of staff told us one person's mobility had declined 'considerably' in the last few months. The member of staff told us, "They used to be up and walk around but they don't anymore." The person's personal 'snap shot' in their care plan still said they were mobile and liked to walk

along the corridors. Their mobility care plan had been reviewed every month since October 2017, but was marked, 'no change'.

Another person was at risk of presenting behaviour that challenged others when they were agitated. Their care plan stated they used 'body language and facial expression or hand gestures' to express their feelings and needs, but there was no explanation of what body language or hand gestures they used or what they might mean by them. The only guidance for staff was to 'speak clearly and slowly, using short sentences' and 'give time to respond when spoken to'.

Care staff did not monitor or analyse the information they knew about people, with a view to implementing a more responsive, person-centred approach. Staff used ABC charts, to record when one person's agitation caused them to present behaviour that challenged others. ABC charts are a nationally recognised observational tool to record information about a particular behaviour. The aim of using an ABC chart is to better understand what the behaviour tells the observer about the person's response to a particular trigger. We found the person's ABC charts were filed in three different places in the person's care plan folder. Not all incidents were recorded on the charts, so the picture of the person's behaviour was incomplete. An incident of challenging behaviour mentioned in the person's daily records on 3 April 2018 had not been recorded on an ABC chart. There was no documentary evidence of the ABC charts being reviewed in the person's care plan folder, despite the fact that staff had been keeping ABC records since at least December 2017. There was no evidence of the incidents being analysed to identify any triggers or patterns, or for staff to identify how they might change how they supported the person to minimise the risks of a reoccurrence.

There was limited documented evidence to demonstrate people were offered opportunities to socialise and engage in activities that were meaningful to them. For example, one person's daily records from 29 March 2018 to16 April 2018 indicated that the only activities they had engaged in were 'watching TV' and 'listening to music'.

We saw people who were able to mobilise independently continued to be able to 'drop-in' to any of the lounges and join in with whatever activity was going on at the time. After breakfast in the unit known as 'Copperfield', we saw people were encouraged to do jigsaw puzzles and play board games to stimulate their minds and staff rearranged the chairs to enable people to share in a chosen activity. We saw several people appeared to enjoy walking around the house, checking where other people were and talking to each other and staff in passing.

People who were able to express themselves verbally had varied opinions about whether staff were responsive to their needs. People told us, "I learn from the staff which helps me. We have girl talk" and "I have been out with a care staff. A couple of weeks ago I did flower arranging. There is a piano man, but I haven't seen him in a month. It would be nice to play cards, dominoes and quizzes to keep your mind occupied." Relatives were equally divided about whether they was enough to do to keep their relations occupied. Relatives told us, "I believe they have activities. I've seen care staff playing as a group and individual one to ones" and "I asked for more activities. I saw a man on an organ and they made some Easter bunnies, but there's no activity sheet."

Some staff told us there was a lack of consistency in the guidance they received for responding to people's social needs. A member of staff told us the inconsistent direction and guidance were, "All very distracting from (delivering) good care." Staff told us the provider did not recognise 'talking and drinking tea with people', as an integral part of care staff's role. Staff told us, "[The provider] watches the cameras and says, 'get off your backside' when we are having a cup of tea with people" and "It could be better. We are trying to improve, but money always blocks that. We cannot take people out. The last minibus trip was last year."

At our previous inspection in November 2017, we found there was little recorded information in people's care plans about people's wishes and expectations for being supported at the end of their life. We were told staff had training to make sure they understood the importance of knowing the person and recognising their spiritual needs and beliefs.

At this inspection we found there continued to be little recorded information in people's care plans about people's wishes and expectations for being supported at the end of their life. The staff training matrix dated 17 April 2018 did not show any dates to evidence that staff had attended end-of-life care. The service is registered to provide accommodation and personal care for older people and people who live with dementia. Many of the people who live at the service are likely to live there until the end of their days. There were no person centred end-of-life plans in place to ensure people were supported to be comfortable, dignified and pain free at the end of their life.

Inadequate

Is the service well-led?

Our findings

The provider has been in breach of the Regulation related to safe care and treatment and the Regulation related to good governance since inspections in 2017. In February 2018, the provider sent us their report of the actions they planned to take to improve. At this inspection we found the provider had not made the required improvements and they were still in breach of the Regulations. We have rated well-led as Inadequate. This is the third time the service has been rated Inadequate in well-led since November 2015.

After the service was rated inadequate in well led for the second time in April 2016: we imposed an additional condition on the provider's registration, to submit monthly reports to the commission identifying actions taken to minimise risk. The provider has not sent us copies of the audit reports by the 28 of each month since May 2017. The manager had sent some audit reports to us, but not by the 28 of each month. The manager told us that she did not have the time to do this.

This was a breach of Section 33 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

There was no registered manager in post. 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 manager had been appointed in June 2017, but had not registered with us. There has not been a registered manager in post since December 2016.

This was a breach of Section 33 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Despite previous inspections identifying shortfalls in governance systems, we found that insufficient progress or improvement had not been made to the systems and processes to audit and improve the quality of care provided at Chasewood Care Ltd and to meet the Regulations. We found systematic and widespread failings in the oversight and monitoring of the service, which meant people did not always receive safe care. The provider had not reviewed or improved risk assessments; they had not completed effective health and safety checks of the premises or equipment; and there was not an effective system to audit care plans to ensure they were up to date. There was not an effective process to ensure statutory notifications were sent to us. The systems in place to monitor and analyse accidents, incidents and falls were not effective to identify trends or patterns.

Service users' care plans were not reviewed and updated when their needs changed. Staff continued to use the same style of risk assessments and care plans which should be based on assessed needs. Care plan reviews were marked as 'reviewed' monthly, but they had not been accurately updated to reflect changes in people's needs. The handover notes that were available did not describe changes in people's individual needs, moods, behaviour or appetites.

The provider's own action plans to improve people's safety through monthly checks and audits, staff training and supervision, more detailed handovers to staff and regular senior staff meetings had not been

implemented effectively. There was no record of staff attending fire drills. Governance meetings had not taken place and there was no evidence to show they had yet been scheduled.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users who live at the home. Their 'registered provider's checks' were inadequate and incomplete.

The provider was unable to find the audits we requested. They gave us a sheet of paper headed, "Registered Provider's Checks", dated 4 April 2018. The document, which was ticked and signed by the provider, said they checked, 'Staff DBS and training, residents' weights, fire safety and health and safety'. This was the only evidence the provider showed us to demonstrate they had monitored and improved the quality of the service since November 2017. The provider told us the manager managed the service and they left the checks to them, but realised they were not completed. The provider said, "My failure is not getting them (the manager) to keep this information."

The provider's fire safety checks had not identified that the premises fire risk assessment had not been reviewed since January 2017. The staff training records for 'fire drill training' were blank, so the provider could not have been assured staff regularly attended fire drill training. The equipment and information 'grab bag' prepared for emergencies did not contain an up to date register of everyone who lived in the building, to support a safe evacuation of the building in an emergency. The lists of the people who lived at the service did not match in number or in the name of the unit they lived in. The provider had not identified the risks to people's safety and wellbeing in removing the direction signs and names of each unit.

The provider's health and safety checks had not identified that there was insufficient mobility equipment to support people safely when they needed support. They were not able to show us any documentary evidence that the amount of mobility equipment available was sufficient to meet people's identified needs to support them safely. The provider had not monitored whether staff checked the safety and suitability of the equipment, to ensure it was maintained and suitable for use, was in good repair and fit for purpose.

The provider's system for reporting, recording and taking action to mitigate further incidents was not effective. Accident and incident forms, daily records, and multi-disciplinary notes were not dated, consistent and the number of individual accident and incident reports did not accurately match the numbers listed in the analysis that informed the audit reports. Action to minimise future risks had not been identified and there was no evidence that learning had taken place to reduce the likelihood of them happening again. The provider was not able to show us evidence they proactively conducted regular premises' risk assessments and took action to minimise the risks they had identified.

The provider's maintenance request log book showed they had failed to respond to repeated requests from the manager and staff to make sure there was sufficient hot water in the communal bath and shower rooms to meet people's needs. They had not identified that their failure to reinstate the directional signs and points of reference in the corridors meant people, new staff and visitors were not able to find their way around easily and independently.

A deputy manager had assured us there have been no errors since the electronic medicines were introduced, but this was not the case. The provider's medicines audits had failed to identify that staff did not document why they had not always administered people's medicines in line with their prescriptions; that staff did not regularly check the temperature of the medicines fridges; or there was insufficient guidance for staff, in the form or protocols, to ensure that medicines prescribed for 'when required', were only administered in in accordance with best practice.

We asked the provider to send us the information related to medicines management and administration that was not available on the day of our inspection, by email after our inspection visit. We expected to receive evidence for those people whose MAR charts we had reviewed that: calming medicines prescribed 'when required' had only been administered when people were agitated; and that staff had adequately explained why they had not administered people's prescribed medicines. Two weeks after our pharmacy inspector's visit, the provider had still not sent us the information we requested.

This was a continued breach of Regulation 17 (1)(2)(a)(b)(f) of the HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance.

The provider had failed to ensure that accurate, complete and contemporaneous records were kept in respect of each service user, including a record of the care and treatment provided and of decisions taken in relation to the care and treatment provided. Care plans were not audited to check whether they were accurate, up to date and reflected people's current needs.

One person's care plan had been created when they lived at the provider's other home. They had had moved to this home in February 2018, but their sleeping and resting care plan was last updated on 9 May 2017, nine months before they moved to the home, and contained out of date information. By the end of our inspection their sleeping and resting plan had been reviewed, but still failed to record that they had moved home. The person's falls risk assessment had been reviewed since they moved to this larger building, but the changes in their environment had not been identified as risks to their health and wellbeing.

One person's care plan folder contained copies of eight applications for deprivation of liberty authorisations to the authorising body (DoLS) for other people as well as the copy of the DoLS application for the person. The information about the DoLS authorisations for the other eight people was not available in their own records.

This was a breach of Regulation 17 (1)(2)(d) of the HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance.

The provider had not been proactive at obtaining people's views of the service to enable them to evaluate and improve the service. There was no focus on the experiences of the care people received, or their opinion of that care. None of the people or relatives we spoke with could remember being invited to attend a meeting, or complete a survey since our previous inspection.

People who were able to express themselves verbally were mostly happy with the management of the home. Two people told us, "I can't ask for better care. Anything I need that I haven't got, they get it for me" and "It's very good." When we asked people what they thought could be improved, two people said, "I'd like to have a warm lunch more often" and "I would say to involve residents to participate in more games. You get bored watching TV."

One relative told us, "It's been the same here since your last inspection. A bit of decoration. I think the management has got a lot better. [Name of the manger] is more organised and its better run." Another relative was concerned that staff did not all wear uniforms and staff did not have name badges. They said, "If there was a problem with a care staff, how would I know who it was?" They were also concerned that there 'appeared to be less staff at weekends' and said, "They need to improve the garden, it's in a state."

The provider had not sought, heard or responded to people's or relatives' views of the service. They had not been able to assess what worked well or what needed to be improved, from the perspective of people who

lived at the home and their relatives.

This was a breach of Regulation 17 (1)(2)(e) of the HSCA 2008 (Regulated Activities) Regulations 2014: Good Governance.

During our review of management records, we identified other incidents that had not been notified to us. Safeguarding records showed that a person had been involved in a safeguarding meeting. The multi-disciplinary meeting had been arranged in response to allegations of neglect by a relative. The matter had been referred to and investigated by the local safeguarding team, but the provider had failed to notify us of the referral.

A relative of another person told us they had complained to the manager about the way two care staff had supported their relation to mobilise. The manager told us they were investigating these allegations with the named members of staff, but they had not referred the allegations to the safeguarding team. The provider had not ensured the manager recognised that this type of allegation constitutes an allegation of abuse. The allegations should have been referred the local authority safeguarding team and we should have notified us of the referrals.

Two people's care plans contained authorisations from the local supervisory body for the provider to deprive the two people of their liberty, in their best interests. Both people were deemed to lack capacity to recognise the risks to themselves of going out of the home independently. This is known as a DoLS authority. The provider had not notified us they had been authorised to deprive these two people of their liberty. The manager told us the provider had been authorised by the supervisory body to deprive an unknown number of other people of their liberty, because they also lacked the capacity to recognise the risks of going out of the home independently, but was not able to supply a list of all the people the provider had been authorised to deprive of their liberty, because the records were not available to them. The provider had not notified us of the unknown number of DoLS authorisations they had been granted by the supervisory body.

This was a breach of Regulation 18: Notification of other incidents Care Quality Commission (Registration) Regulations 2009.

Day to day management of the home was inadequate. At the end of the first day of our inspection, we told the provider we would go back to the service on 20 April 2018, to look at quality monitoring information, analysis and actions they had not been able to show us on 17 April 2018. We shared our concerns about the lack of management and oversight of the service but they did not meet with us on 20 April 2018.

Staff told us they did not feel well led and they received conflicting messages from the provider, the manager and the senior staff. They told us the lack of consistent direction and guidance from the senior management team had a negative impact on their well-being and adversely affected their purpose to deliver good quality care, which affected the service people received. Some staff said they had not been invited to a team meeting since January 2018, so all the information they knew about the provider's and manager's plans to improve the service was 'hearsay', which resulted in rumours and speculation. One member of staff told us the service would improve with more organisation and a "bit more support from the provider". They told us shifts would work better if staff were allocated tasks "We don't know whether we are coming or going. We have a good staff group, but there's no respect or discipline amongst the team."

The provider had not met with the staff to hear their concerns or suggestions for improving the service or explain their plans for improving the service. Staff told us the provider did not communicate with them

directly to share their plans. A member of staff told us, "It would be nice if he communicated with us about the changes he wants to make in the home. He will come down and if, we are sitting down doing the care plans. He will ask what we are sitting down for, but apart from that, no."

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that all allegations of abuse were referred to the local safeguarding authority and had failed to notify us when they did make such referrals

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not operate an effective complaints' handling system that would have enabled them to identify trends or areas of risk that they could have addressed to improve people's experience of the service.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess and take reasonable measures to mitigate risks to the health and safety of service users in relation to people's individual risks and risks associated with the premises, equipment and medicines.

The enforcement action we took:

We issued a Notice of Proposal to vary a condition of the provider's registration, to remove a location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effective systems and processes to ensure they were able to assess, monitor and improve the quality and safety of the services provided. The provider had failed to assess, monitor or mitigate risks relating to the health and safety of service users; failed to maintain securely an accurate and contemporaneous record in respect of each service user; including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provide; failed to seek or act on feedback from service users; and failed to evaluate and improve their practice in respect of processing of the information available to them.

The enforcement action we took:

We issued a Notice of Proposal to vary a condition of the provider's registration, to remove a location.