HC-One Oval Limited

Summerville 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?	**Requires Improvement**

Summary of findings

Overall summary

inspection on 16, 26 and 27 June 2017 and found breaches of the regulations in respect of person centred care, dignity and respect, consent, safe care and treatment, safeguarding, premises and equipment, staffing and good governance. We served a notice of decision to impose a condition on the provider's registration which was for the provider to ask the Commission for their permission prior to accepting any new people into the home. This condition remains in place. The home was placed in special measures.

At this inspection, we found that although there were some improvements there were continued breaches of a number of the regulations. However, the impact for people living at the home was assessed to be mainly low level. You can see what action we told the provider to take at the back of the full version of the report. The registered provider had taken enough action to be taken out of special measures.

Summerville Care Home is a nursing home with three units over two floors. There were areas of the home which had adapted facilities for people. There were 34 people living in the care home at the time of our inspection with a maximum occupancy of 45 beds. 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.

This location requires a registered manager to be in post. A registered manager was 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.

We continued to remain concerned regarding the governance systems within the care home because they had not identified the issues we found on this inspection. Not all safeguarding concerns we found had been reported to the safeguarding authority.

On this inspection we found concerns related to staffing/staff deployment to meet people's care needs. Some staff we spoke with told us they had concerns related to staffing. There had been staff turnover and some positions had been recruited into but staff had not yet started work.

The dependency levels were high with a high number of people requiring two care staff for most care tasks such as personal care and for managing behaviours which were challenging.

We observed people were not always receiving the support they required in order for them to have their nutritional needs met.

The Mental Capacity Act 2005 legislation framework was in place but not always being applied or documented to demonstrate the process being followed.

People told us there were not enough activities or things for them to occupy themselves with. There was a new activities coordinator who had recently been recruited to the home and was waiting for the necessary checks before starting work.

People were not always being listened to and some people told us they felt lonely. People's care was not always person centred.

Care plans were not always providing staff with detailed information for them to know how to best manage people's behaviours which were challenging.

People's dignity was not always being upheld due to the manner in which people were spoken with by staff and due to people not always receiving support when they needed it.

All three recruitment files contained two references but one staff file did not contain the most appropriate reference from a previous employer who was a care provider.

Complaints were not being recorded contemporaneously to see how they had been managed by the registered manager.

On our last inspection we found concerns in relation to the premises and found the home was unsafe. We found improvements had been made on this inspection and the provider was no longer in breach of the regulation in respect of the premises. There was enough personal protective equipment {PPE} for staff to use during our inspection.

On our last inspection we found concerns related to how prescribed medicines were being managed. On this inspection we found medicine management systems were safe. Medicine audits were being completed.

Staff we spoke with understood safeguarding and the different types of abuse. They could describe how to report a safeguarding concern and knew about whistleblowing. However, we found not all safeguarding concerns had been reported to the safeguarding authority.

Staff had undertaken a range of training including safeguarding, mental capacity and infection control. Staff received an induction, supervision but not all staff had received an annual appraisal.

People's cultural and religious needs were being considered by staff within the home. Staff knew people well and could describe people's individual care needs.

A choice of foods and drinks were being offered to people. People provided positive comments about the food.

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.

Not all preventative measures were in place to reduce risks or learn from incidents.

Staff deployment/staffing levels were not always meeting people's care needs.

Staff understood their responsibilities in safeguarding but not all safeguarding concerns had been reported.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 framework was in place but some information was inconsistent.

People's nutritional needs were not always being met.

Staff were offered a range of training.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

People did not always feel listened to.

People were being supported to meet their diverse cultural and spiritual needs.

Is the service responsive?

Requires Improvement

The care being provided was not always responsive.

There were few activities which were not always meeting people's needs.

Care plans we viewed were being reviewed but information was

inconsistent, contradictory or missing at times.

Records of how complaints were dealt with were not detailed enough.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance systems were not robust enough and had not identified all of the concerns we found on this inspection.

Audits being undertaken were not always effective.

The registered manager had implemented new quality assurance systems since our last inspection.

Summerville 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 returned within six months of the service being in special measures to see if they had made improvements. The inspection was also partly prompted by a notification of an incident following which a person using the service sustained a serious injury. This incident was referred to other agencies such as the police and the Safeguarding Authority. The information shared with CQC about the incident indicated potential concerns about the management of risk of people not receiving appropriate moving and handling according to their medical conditions. This inspection examined those risks.

The inspection took place on 12 and 13 March and was unannounced. The inspection team included one adult social care inspector, a specialist nurse advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was caring for someone who was elderly with dementia.

The information gathered and reviewed before the inspection included notifications we had received from the service and a Provider Information Return [PIR] submitted to us on 30 January 2018. This is a document we ask providers to complete and return to us to provide us with information about the service.

Numerous methods were used during this inspection including talking to people using the service, their relatives and friends or other visitors, interviewing staff, pathway tracking, structured observational framework assessment (SOFI), observation and a review of records.

We undertook a tour of the premises and spoke with 13 people living in the home, 11 staff members including the registered manager, area director and the chef. We viewed six people's care plans with associated care records, observed a medicines round, made other observations and also undertook a structured observational framework [SOFI] assessment. We contacted the commissioners of the service and spoke with one healthcare professional.

Requires Improvement

Is the service safe?

Our findings

On the last inspection on 16, 26 and 27 June 2017 we found the service was in breach of regulations relating to safe care and treatment, premises and equipment and staffing. An urgent notice of decision was served to impose conditions on the provider's registration.

On this inspection we found some improvements had been made in relation to specific risks we identified during the last inspection. However, there were other concerns found which related to safe care and treatment and staffing so the provider remained in breach of these regulations. We found concerns related to staffing levels on this inspection. There had been a staff turnover since the last inspection and some positions within the care home had recently been filled but staff were undergoing checks and had not started work. There were a high number of people who were remaining in bed who required two staff members to support them to sit out. We checked the dependency levels of those people and also spoke with people and staff about the staffing ratios. We viewed the rotas and made our own observations of how staff managed with the staff numbers they were working with. We also viewed the call bell response times to ascertain how long people were having to wait for their care. We were present when a staff member entered one person's room and said – "really sorry we should have taken you downstairs but we've been too busy".

One staff member told us in confidence they had concerns about staffing levels in the home. They told us they were struggling to provide people with their personal care within the time available due to staffing levels not meeting the dependency levels of the people at the home.

One person who lives at the home told us – "They are rushed [meaning the staff] but lovely." A second person told us – "I would love someone to read to me. I'm lonely." A third person said – "if someone could come and chat for a little bit."

We talked to the registered manager about staffing levels and we were informed there were eight carers dropping down to six in the afternoon, a hostess, an activities coordinator and two registered nurses on shift each day. We were also informed there was a staff member who was tasked to write up care plans sitting in the lounge who would step in and assist with delivering care at times when staff were busy. We however, observed the staff member was present in the lounge when one person was struggling to eat their food due to their health condition affecting their posture and the staff member did not assist them. We then checked the person's care plan which stated the person needed - "food cutting up". Other staff also told us the staff member sitting in the lounge would come and find them to ask them to provide care instead of assisting the person. Another person was seen struggling at evening meal time in their bedroom. The person was alone and had spilt some of the pasta meal onto the bedding. We asked the area manager to ask for staff to assist the person. We were therefore, concerned not everyone was receiving enough to eat and drink due to staffing levels and them not receiving the support they needed to eat and drink.

We observed a hostess working in the kitchen on 13 March 2018. We looked into this and found the hostess was told to come off the floor providing drinks for people, to work in the kitchen due to the kitchen being short staffed. We found this was a regular occurrence and care staff were required to provide drinks at these

times. We also found the activities coordinator had left since our last inspection and the registered manager was recruiting a new activities coordinator.

On the rotas we viewed we found the staffing numbers had reduced down to four care staff after 2pm on 12 March 2018. The call bell print out response times we viewed showed occasions when people had waited for up to 19 minutes for staff to respond. This meant the staffing levels/deployment of staff was not effective in always meeting people's care needs.

This is a breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2008 [Regulated Activities] 2014.

We checked three staff recruitment files and found they all contained an application form, Disclosure and Barring Service [DBS] check and references. Of the three files we checked we raised concern in relation to two staff member's references. One staff member had provided two references from the same employer and a second staff member had not provided a reference from their previous care employer. We were assured by the area director more robust checks would be undertaken for all newly recruited staff going forwards.

We looked into the system of recording and reporting incidents and accidents. We had been informed of a serious incident whereby one person had fractured their arm during a care task. We received a root cause analysis of the serious injury. We asked the registered manager what else had been actioned to prevent this type of injury from reoccurring. The registered manager said they had ensured staff had information about the person's condition who had sustained the serious injury. We viewed the information given to staff and found it was information obtained by the registered manager off a website on the internet. It was unclear whether the website information was accurate or reliable. There was no guidance for staff in the information seen regarding how to reduce the risk if they were delivering care for someone with the medical condition. The area manager agreed more information could have been obtained from known reliable sources to ensure staff were being provided with enough information which was both effective and reliable. We were informed additional information from a reliable source would be provided for staff following our inspection.

A staff member told us there was a risk of one person biting staff when they were delivering care. We looked into whether there had been any incidents and viewed an accident form dated 17 July 2017 where a staff member had been bitten by the person. There was therefore, a history of this behaviour as it was also documented in the person's care records. One entry stated - "protecting residents head whilst hoisting and resident bitten my arm (right)" - "Deep bite with blood and bruising". Despite these behaviours we found no care plan in place for staff to know how best to reduce the risk of these behaviours being triggered. The registered manager agreed to implement a care plan and also to add additional detailed information within their mental health care plan.

We viewed another entry for another person which stated "9 March 2018 physically aggressive; punched and scratched care staff during morning care. Mood has been aggressive but did not remember anything". We asked to see the incident record for this incident. The Registered Manager confirmed no incident form had been completed. This incident had also not been written on the incident tracker.

This is a breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2008 [Regulated Activities] 2014.

Staff we spoke with had knowledge of safeguarding and the different types of abuse they needed to look out for. There was a system in place of recording safeguarding concerns. The tracker we viewed detailed what the safeguarding concern was related to, whether the safeguarding concern had been reported and

substantiated or not. Staff had heard of whistleblowing and described what to do if they had concerns. However, we found one person's care records evidenced they were declining their personal care but this had not been identified as a safeguarding concern. We found not all safeguarding concerns such as self neglect had been reported to the safeguarding authority.

This is a breach of Regulation 13 Safeguarding service users from abuse and improper treatment

We checked if medicines management systems were safe. We observed a medicines round and checked the medication administration sheets (MAR). We found there were no gaps in the MAR charts we reviewed and there was evidence of Pro Ra Nata (PRN – which means as and when medication) protocols. The registered nurse we observed administering medicines was seen following good practices such as ensuring single pots/beakers were being used for each medicine for a person. There was no one receiving prescribed covert medication and there was no evidence of covert practices during the inspection. The medication trolley was seen locked securely at all times. Safe practice was also observed to support a person who was known to have swallowing difficulties. Controlled drugs were locked away securely in the clinic. A random spot check reflected the stock totals in line with the controlled drugs register. Fridge temperatures in the clinic were being monitored daily.

We observed effective systems in Infection control including use of personal protective equipment (PPE) by staff. One staff member we spoke with told us "PPE never runs out". Staff were seen cleaning and domestic rotas were seen in communal bathrooms. We undertook a tour of the home and did not find any concerns related to the cleanliness of the environment.

We viewed the maintenance files and found a system in place of reporting and recording small repairs needed. The Personal Emergency Evacuation Plans {PEEPS} were viewed and we asked the registered manager to further improve the detail provided within the PEEPS in the event of an evacuation. There was a colour coded system on display but it was unclear how many staff would be needed to support a person in an emergency.

The home received a five star rating for Food Hygiene following their inspection on 28 February 2018 and a 98% score for compliance with infection control.

Requires Improvement

Is the service effective?

Our findings

On our last inspection on 16, 26 and 27 June 2017 we found the service was in breach of the regulation in relation to consent. This was due to people not always being asked for their consent prior to care being delivered. On this inspection we found concerns related to the Mental Capacity Act 2005 legislation not always being documented clearly to demonstrate it had ben adhered to.

We looked at whether the Mental Capacity Act 2005 (MCA) was being followed. The 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 r any conditions on authorisations to deprive a person of their liberty were being met.

We found a framework in place in the care plans we viewed where people's mental capacity was being assessed and best interests decisions recorded. The information seen was inconsistent and contradictory at times. For example, we viewed an entry in one person's mental capacity care plan stating - "staff to encourage {person} to take part in social activities in the lounge, speak clearly and concisely". Then it stated "Unable to make decisions lacks capacity". Then in another section of the care plan it stated "{person} can consent/refuse to be assisted with skin care by turning their head away or moving their eye contact. In very rare occasions can bite if not happy with care. Gain consent prior to assisting with skin care".

Another person's mental capacity in relation to health decisions was not being clearly documented to always demonstrate the principles of the Mental Capacity Act 2005 were being followed. The person's GP had undertaken a mental capacity assessment for a specific decision to refuse treatment but there was no reference to this best interests process being followed in the person's care plan. Other specific decisions had not been assessed in line with the MCA legislation such as the person's capacity to decline receiving personal care which was evidenced in their records.

The care plan also included a "Do Not Attempt Resuscitation" form which showed that the instruction not to resuscitate had not been discussed with the person and had been agreed with a relative who was reported to have lasting power of attorney {LPA} for Health and Welfare. There was no evidence in the person's care plan to demonstrate a copy of the legal document confirming a LPA was in place and the date that it came into effect.

This is a breach of Regulation 11 Consent of the Health and Social Care Act Regulations 2008 [Regulated Activities] 2014.

We checked how well staff knew people. One person who lived at the home told us – "Staff know me well.

They know my name". A relative we spoke with said – "I have no concerns about staff and how they look after people here." When speaking with staff about people, they knew people well and could describe their care needs.

There were links with a community nurse liaison who visited the home during our inspection. Involvement with other professionals was clearly seen in people's care records such as with healthcare professionals, local authority and continuing health care.

We viewed staff training records and found the qualified nurses working in the home were being supported to undertake the National End of Life Qualifications and 6 Steps Programme. All staff were offered training in a range of topics from behaviours which are challenging training, preparing thickened drinks, moving and handling, safeguarding, medication management training with competency checks for nurses and there had been a workshop titled – "Dignity in Care" which 27 staff had signed they had attended.

Staff told us they had received an induction lasting four days including classroom based training and shadow shifts. Staff confirmed they had received. We checked the supervision tracker in place and found it was documented when staff were receiving their supervisions. There was also a system of recording when staff received an appraisal. We viewed the appraisals tracker and found some staff had not received an appraisal since 2016 and were therefore, not receiving annual appraisals. Some staff told us they had not received an appraisal. This meant not all staff were being provided with the opportunity of discussing their job role with objectives for the forthcoming year.

We viewed in people's care plans some choices were being assessed and recorded. Choices recorded included the choice to spend time in the lounge, choice of what to eat or drink and choice of eating in their room. We spoke with one person whose medical condition had changed over time since living at the home. We were concerned not all that could be done had been done to assess the support the person required in order to maintain their independence within the home.

People who could converse with us told us what they thought about the food. One relative told us – "Yes she loves the food, I've seen her eat well when I come." A person who lived there said – "Food is good. I get plenty to eat and drink." A second person told us – "Food is ok".

There was a hostess who prepared drinks for people and there was a clear system in place of making sure people who required them had their prescribed thickener in their drinks. We observed during a lunch time period that people were offered an extensive choice of drinks. We observed one person had a glass of beer with their meal. Another person told us they had wine with theirs. The food was served from a hot trolley and was plated up from a list of people's names. We heard people say the food was nice, tasty and hot.

Aspects of the environment were not always adapted for people's needs. For example, we found no props, memorabilia or sensory areas suitable for people living with dementia. However, people's rooms were being adapted to meet their needs as much as possible. We observed one person's room looked out onto a garden area where there were numerous bird feeders. They had been specifically placed in front of the person's window due to their enjoyment of bird watching. The seats in the lounge had been moved into clusters by the second day of our inspection so people could converse and interact as much as possible if they wished.

Requires Improvement

Is the service caring?

Our findings

On our last inspection on 16, 26 and 27 June 2017 we found the service was in breach of the regulation in relation to dignity and respect. We found some concerns on this inspection and found the provider remained in breach of this regulation.

We asked people if staff were caring. One person said – "Very kind to me, not had any problems up to now", a second person told us – "I am respected up to now," a third person said – "Nice to me", a fourth person told us – "Staff put my makeup on, that's respectful," a fifth person told us – "They are rushed, but lovely". A relative told us their relative who lived at the care home had been – "rough handled" – this was being investigated at the time of our inspection. A second relative told us – "I see staff treating people right," A third relative told us – "I have no concerns about staff and how they look after people here." A fourth relative said – "Yes I believe they {meaning staff} are kind and caring".

We spent time with people in the lounge and other communal areas of the home to observe interactions and how staff communicated with people. We heard a mixture of comments both positive and negative. For example, one positive comment we heard was a staff member explaining to one person what was on the spoon whilst being supported to eat. An example of a negative interaction we heard was when a staff member said to another staff member- "we need a urine sample from her {service user}" in front of other people in the lounge.

We were made aware of one person who lacked capacity whose care needs had changed since they came to live at Summerville Care Home. We asked the registered manager if they had referred the person for advocacy services. We were informed by the registered manager a referral to advocacy had been discussed but had not been actioned. The manager agreed this would be beneficial for the person and confirmed they would action this immediately.

Not all staff demonstrated kindness or empathy despite being aware when people needed assistance. For example, we observed a staff member who had not responded to one person struggling with their food. The person who was struggling with their food said to us "I'm struggling a bit here". We informed the staff member in the lounge who responded by saying - "normally she {meaning the service user} is ok". The staff member then asked another member of staff who was already providing care for a different person to assist when they were able to. We discussed this with the registered manager and the area manager who agreed this practice was not acceptable.

These issues are a breach of Regulation 10 Dignity and Respect of the Health and Social Care Act Regulations 2008 [Regulated Activities] 2014.

Staff were observed delivering care respectfully by firstly knocking on people's bedroom doors before entering the room and asking the person for their consent before they began the care task. People were also asked for their consent to administer medication in a caring and respectful manner.

Some people we spoke with told us they were lonely. We looked into how much people were being listened to and involved in the home. There was a 'resident of the day' system in place whereby staff reviewed the person's care with them on their day. Residents/relatives meetings were being held.

Tables in the dining room were set with flowers, cutlery, condiments and napkins creating a homely dining environment. We observed staff making sure people who needed a plate guard had one to enable the person to be as independent as possible when eating. Several people were observed being nursed in bed, including at mealtimes. There was no evidence of efforts to get them up into a chair or support them into the communal lounge which impacted on opportunities for social interaction and a greater quality of life. The provider agreed to review each person who was being nursed in bed to ascertain which of those people could sit out of bed who wished to.

We looked into how the service were meeting the diverse needs of people according to Equality, Diversity and Human Rights legislations. We spoke with some people who told us their religion. One person said "I am a Christian. We have a service done here that I go to. I would like to go to church." Another person whose dietary requirements were specific was receiving a diet appropriate for them to meet their cultural needs.

Requires Improvement

Is the service responsive?

Our findings

On our last inspection on 16, 26 and 27 June 2017 we found the service was in breach of the regulations in respect of person centred care as the care being provided did not reflect people's preferences. We saw some people's preferences recorded within their records but we continued to have some concerns related to person centred care.

We looked into the activities for people in the home. We asked people about activities and if there was enough for them to do of interest for them. One person told us – "There is not a lot going on, I'm bored." A second person told us - "There isn't much going on." A relative said – "There isn't enough to do." Another relative said – "There could be more to do for people."

We were told the activities coordinator position had been vacant for a period of time and they had recently recruited and were waiting for the new activities coordinator to start working 30 hours each week in the home. In the meantime activities were being provided by a staff member for two and a half days per week and staff were undertaking one to one activities with people but had little time to do this. We observed people sitting around doing nothing for long periods of time. We observed a game of floor snakes and ladders but people did not appear to be joining in. The small amount of interaction we did observe was not meaningful to people.

One person whose care plan detailed they were living with a mental health condition. We viewed the section in the care plan related to their mental health and found there were no details to provide staff with information about their condition. It is important for staff to have information about people's mental health for them to look out for signs or symptoms so healthcare professionals can review the person's mental health. We also found two people who sometimes displayed behaviours that challenged had no specific care plans with person centred information related to what their behaviours were, what triggered them or strategies for staff to know how best to respond. The registered manager agreed they would write detailed mental health care plans and behaviours which challenge care plans for those which were missing.

One person who we met in their room told us they wanted more contact with people. Their care needs had increased over time as they had become less independent in walking to find people to speak with. The person was unable to seek contact with others independently and was reliant on staff to accompany them. Their care plan detailed how the person liked stories to be read to them and there was evidence seen in the records staff were attempting to do this. The care plan had not detailed the person's wishes or aspirations to mix with others and to talk to people despite them no longer having the confidence to walk independently to another person's room or to walk to the lounge downstairs. We discussed this with the registered manager and area manager who acknowledged there was a lot more they could do for the person to support them to socialise with others.

These issues were a breach of Regulation 9 Person Centred Care of the Health and Social Care Act Regulations 2008 [Regulated Activities] 2014.

We looked into how complaints were managed in the home. One person told us – "I've no complaints up to now." A second person told us – "I've no complaints." There was a complaints procedure in place and a complaints policy.

There were seven complaints/concerns recorded since June 2017 in the complaints file we viewed. The complaints log we checked was not detailed enough and did not include enough information such as the date when the Registered Manager had spoken to people as part of their investigation, details of what was said or agreed with actions. This meant there was not a detailed enough contemporaneous record of how the complaints were being managed with a clear outcome for the complainant.

This is a breach of Regulation 16 of the Health and Social Care Act Regulations 2008 [Regulated Activities] 2014.

The home were providing end of life care at the time of our inspection. There was an end of life policy in place and nurses were being trained in end of life care.

Requires Improvement

Is the service well-led?

Our findings

On the last inspection on 16, 26 and 27 June 2017 we found the service was in breach of the regulations in respect of good governance. On this inspection we found the provider remained in breach of this regulation.

We asked people about the management of the home. One person said – "I don't know the manager." A second person told us – "I'm not sure who the manager is". A third person told us – "I've seen her in here (lounge)." A relative said – "I know who she is. There are relatives meetings. I get the minutes." Staff we spoke with provided both positive and negative comments about the management of the home.

We remained concerned there were issues found on this inspection which had not been identified through the manager's own quality assurance checks. For example, one person receiving care had an advanced decision in place. We viewed the care plan audit for the person's care plan and found the auditor had not identified the person had an advanced decision in place. The system in place for reviewing care records was also not robust. Care plans were not always providing all of the information staff needed such as for how to deal with behaviours which were challenging. The care records we viewed dated 7, 8 and 9 March 2018 which required a counter signature daily had no counter signature which meant the system of checking the care provided and documentation was not effective.
We found the registered manager had not raised a safeguarding concern which would have required them to also provide us with a statutory notification.

Recruitment practices were not always robust enough as we found thorough checks including requesting a reference from a previous employer who was a care provider had not always been undertaken by the registered manager.

The registered manager had not always acted to safeguard people when appropriate. For example, one person had declined personal care on several occasions however this had not been reported to the safeguarding authority as self-neglect. We asked the provider about this and they confirmed they retrospectively reported this during the inspection.

We found the registered manager was aware the maintenance checks for call bells were only undertaken when a fault of a particular call bell was reported in the maintenance log book. There were no regular checks being undertaken such as monthly or weekly system checks of all call bells. This is important to ensure all that could be done was being done to mitigate the risk of a person requiring assistance in an emergency not being able to activate the alarm.

We raised concern with the registered manager an incident form had not been completed. The registered manager confirmed they had asked the staff member who witnessed the incident to complete it but they had not. The registered manager said they would raise this in supervision with the staff member. We raised concern about this due to the length of time in between the incident and the incident form being written to ensure the information is accurate. The registered manager then agreed to speak to the staff member and

ask them to complete it before they ended their shift. We were concerned regarding the leadership in ensuring staff always followed procedures and policies to ensure there is a contemporaneous record of all incidents.

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

We asked the registered manager how they had improved the service since our last inspection. The manager told us they had implemented new systems such as a night time spot check, handover meetings, a meeting called Ten at Ten for any concerns to be raised, resident of the day, an improved more robust system to administer prescribed thickeners, a home improvement plan, lessons learnt resource file and monthly medication audits.

The managers were keeping people informed of recent changes. We were provided with a letter which had been sent to people who lived at the home to inform them of the change in care provider since our last inspection.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's needs were not always being fully assessed for staff to be able to deliver person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People's respect and dignity were not always being upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The Mental Capacity Act 2005 framework was in place but best interests processes were not always evident within the care records seen.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	We found care plans were not always in place for staff to always know how to deal with people's behaviour's which were challenging. Not all incidents had been recorded in a timely manner.

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 We found not all safeguarding concerns had been reported to the safeguarding authority such as when people were declining their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We found detailed contemporaneous notes were not in place to demonstrate how each individual complaints was being dealt with.

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 the problems we found on this inspection and were not robust enough.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing We found staff deployment and staffing levels were not always sufficient in meeting people's care needs.