Medingate Limited

Morningside Rest Home

Inspection report

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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

This inspection was carried out on the 15 and 22 August 2017. The inspection was unannounced on the first day and announced on the second.

A registered manager was in post who had been registered with the CQC since September 2014. 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.

Morningside Rest Home is registered to provide personal care and accommodation for up to 31 older people. At the time of the inspection there were 29 people using the service. The service is spread over two floors and has parking to the front and a garden to the rear. It is set in a residential area within the town of Winsford in Cheshire.

At the last inspection in January 2017 we identified concerns in relation to the safe administration of medication and the efficacy of audit systems. Following the inspection we imposed a condition on the registered provider which meant they had to employ an external professional to monitor and manage the safe administration of medication. At this inspection we identified that issues in relation to medication had been resolved, however issues around audit systems had not been resolved. In addition we identified further concerns about the service.

Audit systems were not effective. These had failed to identify issues found during the inspection in relation to the safety of the environment, infection control, care records and people's safety. The registered manager and registered provider had failed to take action in response to incidents that had occurred to prevent these from happening again.

The safety and security of the premises was not sufficient to protect people from harm. One person had fallen down steps at the rear of the premises, and one person at high risk of falls had been able to access the stairs. In one incident a person at risk of leaving the premises without support had been able to do so, and on another occasion staff had managed to stop a person just prior to them leaving the premises. On one occasion the kitchen was unlocked and unattended for a substantial amount of time. The front door was not locked on our arrival, and the side gate was open which enabled access in and out of the premises through patio doors into people's bedrooms. Prior to leaving on the first day of the inspection we ensured that the registered manager had taken action to address these issues.

Parts of the environment had not been maintained to an adequate standard. A hand rail in the passenger lift had fallen off and hit one person on the foot. Infection control procedures were not always robust. Stains were found to three people's beds, and one person's carpet was badly stained. Hand washing facilities were not available in one bathroom, placing people at risk from infection.

Adaptations had not been made to the environment to promote the wellbeing of those people living with dementia. For example there were steps in the back garden which posed a risk to people who were at high risk of falls. The registered manager had temporarily cordoned these off with a garden chair. In addition there were no objects to help people to orientate themselves within the service, in line with best practice.

Risk assessments were not always up-to-date or fully completed. For example malnutrition risk assessments had not been completed to enable a full analysis regarding the risk of people losing weight. In another example a person had been assessed as low risk of falls despite having sustained a number of falls over a two month period.

Deprivation of Liberty Safeguards (DoLS) had been applied for by the registered manager. However the registered provider was not able to fulfil their responsibilities under the Mental Capacity Act 2005 (MCA) due to failings in ensuring the premises was secure. We identified examples where people had managed to leave the premises without the required support which showed that staff had failed to adequately safeguard them from harm.

Supervisions were not being completed as required. At the last inspection in January 2017 we also identified that these were not completed. This meant improvements had not been made. Supervision enables the registered manager to maintain a record of staff performance. They also help keep staff accountable for any performance related issues.

Not all staff spoke to people in a kind of dignified manner. The registered provider had completed a survey in which some people had stated that "one or two" staff were not always kind to them. During the inspection we identified one member of staff who shouted at people in the lounge area, demonstrating an undignified and disrespectful approach. We raised this with the manager as a potential safeguarding and performance related issue. Following the inspection we raised this with the local authority.

People's confidentiality was not always protected. Staff handover took place in the lounge/ dining room during which personal information about people was discussed. Other people were present in the dining room whilst this was taking place. The staff office was left unattended at times, which left confidential information at risk of being accessed by unauthorised individuals.

People's care records did not always contain up-to-date or accurate information. This meant that staff did not always have access to important information about people's care needs.

There were sufficient numbers of staff in post to meet people's needs. People commented positively on the number of staff available, and told us they did not have to wait long for support when they pressed the call bell.

Recruitment processes were safe and helped ensure that people were protected from harm. Checks had been completed on staff prior to their employment to determine their suitability for the role.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'.

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.

The premises were not secure and sufficient action had not been taken to protect people from harm in response to accidents and incidents.

The environment was not always adequately maintained which placed people at risk of harm.

Infection control procedures were not always robust which meant that parts of the environment were not clean.

Is the service effective?

Inadequate

The service was not always effective.

Supervisions had not been completed as required with staff.

The registered provider was unable to ensure people were appropriately safeguarded in line with the requirements of the Mental Capacity Act 2005 due to poor security of the premises.

Adaptations had not been made to the environment, in line with best practice, to promote the wellbeing of people living with dementia.

People commented that they liked the food that was available, and staff were aware of those people with special dietary needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all staff spoke to people in a dignified manner.

People's confidentiality was not always protected.

We observed some examples where positive relationships had been developed between people and staff supporting them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always up-to-date, and did not always contain accurate information. The review process for care records had failed to identify this which showed it was not effective.

There were activities in place for people to protect them from the risk of social isolation. Some people commented they would like more variety.

There was a complaints process in place which was available to people. People commented that they felt able to make a complaint if they needed to.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider and registered manager had failed to respond to known risks which had placed people at ongoing risk of harm.

Audit systems were not effective and had failed to identify issues found during the inspection.

A culture of openness and transparency was not always promoted amongst staff.

Morningside Rest 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.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management of risk in relation to the security of the premises, and falls from height. This inspection examined those risks.

This inspection took place on the 15 and 22 August 2017. The inspection was unannounced on the first day and announced on the second.

The inspection was completed by two adult social care inspectors, a medicines inspector and an expert by experience who had experience of supporting older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the notifications that we had been received in relation to the service. We used this information to plan the inspection visit. We also contacted the local authority safeguarding and commissioning teams who raised some concerns about the service which we took into consideration.

During the inspection we spoke with 12 people using the service and three people's family members. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with one visiting health professional, four members of staff and the registered manager. We looked at seven people's care records. We also looked at other records pertaining to the day-to-day management of the service such as maintenance records, audits and staff recruitment files. We made observations on the interior and exterior of the premises.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service. One person commented, "Oh yes, I do, definitely feel safe". People's family members also commented that they felt their relatives were safe. Their comments included, "[My relative] was dead anxious when they were living at home, but since coming here they are looking so much better". Whilst we received positive comments about the safety of the service, we identified some issues with the safety of the service.

At the last inspection in January 2017 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to poor management of medication. We imposed a condition on the registered provider around the management of medication. At this inspection we found appropriate action had been taken to address these concerns. However, we also identified concerns which meant there was a continuing breach of Regulation 12.

Accident and incident records showed that there had been incidents where people had been able to leave the service without the required level of support. In one incident a person had managed to leave via the front door whilst a delivery was being made. This person had been stopped by staff prior to leaving the premises. In another incident one person had managed to leave the premises and get a taxi to Manchester. Whilst no harm had occurred as a result of these incidents, we identified that appropriate action had not been taken to mitigate the risk of these incidents happening again. This placed people at high risk of potential harm.

Action has not been taken to make the environment safe in anticipation of risk. An incident record showed that one person had had fallen six times over a two month period and sustained four additional unexplained injuries which may be indicative of unobserved falls. Despite this, the stairs had not been made secure which had enabled them to access these. Staff had found this person sat at the top of the main stairs, following which input from medical professionals determined that they had sustained a fracture to their vertebrae. Another person had also sustained a fall down the steps leading from the laundry into the back garden. This person had sustained cuts to their face and knees and was subsequently taken to the accident and emergency centre. These incidents showed that the environment was not safe for people and had resulted in people coming to harm.

On arriving at the service the front door was unlocked and we were able to walk straight in. There was no sensor on the door to alert staff to our entry. When staff realised we were in the premises they did not ask to see our ID or ask us to sign in. This compromised the security of the premises because it meant that people could leave without staff knowing, and that individuals without authorisation to access the premises could do so. We raised this with the registered manager who followed up on our concerns with staff. She informed us that staff had left the door open so that other staff could enter, without them having to come and let them in. Throughout the remainder of the day we periodically checked on the front door and found that it was secured. Following the inspection the registered manager confirmed that they were improving access via the front door to make it more secure.

During the inspection we found one person's bedroom door was open. This bedroom had a patio door which gave access to the garden which was also ajar. Through this we were able to access the garden, before making our way through an open gate at the side of the premises to the front of the service. The front was unsecured and allowed access to a busy road. Within the service there were a number of people living with dementia, who were restricted by law from leaving the premises in order to protect them from harm. The poor security of the service meant there was a risk that these people would be able to leave the service unnoticed which placed them at risk of harm. It also meant that unauthorised individuals could access the premises, which meant that people were not safe. We raised this with the registered manager who immediately ensured that a chain was placed on the side gate to secure it.

The kitchen had a back door which enabled access to the garden via steep steps. During the inspection we observed that kitchen staff were having a break in the garden and had left the rear kitchen door wide open. The main access to the kitchen did not have any lock in place, or means of securing access. This meant that whilst the kitchen was unattended, people were at risk of being able to access this and the cooking appliances and equipment inside which cause injury to people such as the oven and knives. People were also at risk of falling down the steep steps whilst the back door was open. We raised this with the registered manager who acted to put a lock on the kitchen door.

Another bedroom door was open and allowed access to a fire escape which was not locked. This fire escape led to a steep set of steps which had discarded food items strewn over this. There was a pungent smell coming from these items which showed that they had been there for a while. These items posed a slip hazard to anyone who accessed the fire escape route. We raised this with the registered manager who told us this bedroom would be locked as a temporary measure until a more permanent solution could be found. This was not the main fire escape route and therefore locking this door did not prevent people from accessing a fire exit in the event of an emergency.

Risk assessments were not always completed as required. For example, one person who was at risk of malnutrition and weight loss due to a decline in their physical health had no risk assessment in place around this. This person did not have any other risk assessments in place to identify whether they were at risk of developing pressure sores or falls. In another example, one person had fallen multiple times over a two month period however their moving and handling risk assessment identified them as being at low risk of falls. This person had also sustained fractured vertebrae during an unobserved fall. Malnutrition risk assessments did not include a record of people's heights which mean that their Body Mass Index (BMI) could not be determined. BMI is a nationally recognised means of determining whether people are under or over weight. This means that staff would not be aware if people were under or overweight and therefore could not take appropriate action to refer them to the relevant health professionals for support. We followed up on this and found that no one had come to harm because of the poor weight monitoring.

Parts of the premises were not safe or well maintained. In one instance a handle in the passenger lift fell off the wall causing minor bruising to one person's foot. We identified two fire doors within the service that did not have intumescent strips in place which meant they would not be effective in the event of a fire. An intumescent strip expands in extreme heat, creating a seal which prevents the spread of fire. Two other fire doors were also propped open with foot stools which meant that they would not close in response to the fire alarm and would therefore be ineffective. The fire door at the top of the main staircase had a gap at its base which would reduce its efficacy at preventing the spread of fire.

Infection control processes were not always robust. One bathroom did not have any functioning hand washing facilities or soap for staff to wash their hands after supporting people with personal care tasks. The registered manager confirmed that the sink in this bathroom had been disconnected since July 2017. We

asked the registered manager to take action to rectify this. The mattresses and beds in three bedrooms were stained with urine, and the carpet in another bedroom was also badly stained. We raised this with the manager so that action could be taken.

These are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because premises were not safe, appropriate action had not been taken in response to risk and infection control procedures were not robust.

The Health and Safety Executive (HSE) requires that water temperatures within care homes be monitored to ensure that vulnerable people are not at risk of scalds. Maintenance records showed that water temperatures were being monitored to ensure that they were being kept within a safe range.

A fire risk assessment had been completed and action taken to address any concerns raised. For example this had identified that the cellar was filled with combustible materials. We checked and found that the cellar had been cleared. A legionella risk assessment had been completed and the water supply had been sampled to ensure that it was free from harmful bacteria. A service of the lift had been completed to ensure it was in working order. Hoists and slings had also been checked and serviced to ensure they were safe. This helped to protect people from harm.

Staff had received training in safeguarding vulnerable adults and were aware of how to report any concerns they may have. Staff were aware of whistleblowing procedures and how to report any concerns outside the organisation, either to the CQC or the local authority. Whistleblowing is a process whereby staff can report concerns without fear of reprisals. This helped ensure that appropriate action could be taken to protect people from harm in response to concerns.

Recruitment processes were safe. Staff had been required to provide a reference from their most recent employer and had also been subject to a check by the disclosure and baring service (DBS). The DBS informs employers where potential staff may have a criminal record, or if they are barred from working with vulnerable groups of people. This enabled the registered provider to make decisions regarding the suitability of prospective employees.

One person commented, "They're always there when you need them" whilst other commented that they did not have to wait for support if they pressed the call bell. During the inspection we observed sufficient numbers of staff to meet people's needs.

People were supported to take their medication as prescribed. We observed staff giving people their medication safely, ensuring that these had been taken before signing the medication administration record (MAR). We looked at the MARs for all people using the service for the past two months and found that these were being signed by staff as required. Protocols were in place for those people who had been prescribed 'as required' (PRN) medication. PRN medication is given in response to particular symptoms. These protocols provided clear information to staff around when to give these.

Inadequate

Is the service effective?

Our findings

People told us the service was effective. They commented that staff provided support in a skilled and appropriate manner, and made positive comments about the food that was available. However, whilst we received some positive comments we identified some concerns.

At the last inspection in January 2017 we identified that staff supervision and appraisals were not being completed. During this inspection we found that improvements had not been made. Supervision records identified that only seven out of 29 staff had received supervision in 2017. The registered manager confirmed that these had not been being completed. Supervision helps to keep staff accountable and keeps a formal record of performance. It also allows staff to set goals or discuss any issues they may have. Following the inspection the registered manager confirmed that a plan was in place to ensure supervisions would be provided to staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had not been provided with supervision.

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 registered manager had applied to place people under a DoLS where required.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found that they were not. In one instance a person had been able to leave the premises and get in a taxi before travelling a considerable distance. This person had been under a Deprivation of Liberty Safeguard (DoLS) which required that staff restrict their access outside the premises due to them being at risk of coming to harm. In this instance staff neglected to ensure that sufficient measures were in place to protect this person from potential harm. At the time of the inspection we identified multiple examples where the registered provider had failed to ensure the premises were secure, and therefore the registered provider was not able to fulfil the obligations required by the MCA 2005 to keep people safe.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had failed to safeguard people from harm.

There were people using the service who were living with dementia; however no adaptations had been

made to the environment to help improve or maximise their sense of wellbeing. There were no objects of interest in corridors to help people remember their way about the service or support with orientation. Parts of the service were dimly lit. This can have an impact upon the visual perception of people living with dementia who sometimes experience a decline in their spatial awareness. The use of different colour schemes had also not been considered in relation to best practice around supporting people living with dementia to recognise their environment. The back garden contained steps which had temporarily been cordoned off using a garden chair. This showed that adequate consideration had not been given to the design of the garden as the steps posed a risk of people injuring themselves. Following the inspection the registered manager confirmed that these had been fenced off to minimise the risk of injury.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because adjustments had not been made to the environment to promote the wellbeing of those people living with dementia.

In a majority of examples we observed people being given choice and control over their care needs. People commented that they were able to get up in the morning when they chose, or go to bed at a time that suited them. We started the inspection at 6am which enabled us to confirm that people were able to wake up at a time of their choosing. People also commented that they were able to go outside in the garden if they wanted, or walk around the building.

Training records showed that a majority of staff had completed training in those areas required for them to carry out their roles effectively. Where there were gaps in the training records the registered manager was able to provide certificates following the inspection which showed that staff had completed training in these areas. Training completed by staff included moving and handling, infection control and fire safety amongst others. There was an induction in place for new staff, which included a period of shadowing experienced members of staff. This met a majority of the standards required by the care certificate. The Care Certificate is a national set of standards that health and social care staff are required to meet. We asked that the registered manager review the induction process to ensure it incorporated all the standards required by the Care Certificate.

People commented positively on the food that was available and had a choice of sitting in the dining room or their bedroom. People were offered a choice of meals, and alternatives were available for those who did not like what was on offer. The kitchen was clean and there was a variety of tinned and fresh produce available for meal preparation. Full fat milk and cream was available to support those people at risk of weight-loss to maintain their weight.

People's care records showed that they had been supported to access their GP or other health professionals where required. In emergency situations staff had contacted paramedics. A record of input from professionals was maintained in care records, which ensured staff remained aware of issues that were on going.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring towards them. Their comments included, "They're all nice girls, they know what I like" and "They're very good and very caring". However, a recent survey completed by the registered provider showed that four people had stated "one or two" staff were not always kind or respectful. Family members spoke positively about staff. One family member commented, "This is a nice place, with kind people".

On the first day of the inspection, we observed a handover take place between the night and the day staff in the lounge/ dining room. Handover is where information is shared between shifts so that staff are made aware of any important issues that need to be followed up on. There were other people sat in the lounge/ dining room at the time of the handover who were able to hear the confidential information that was being discussed. This impacted on people's confidentiality. We raised this as an issue with the registered manager and on the second day of the inspection, the handover took place in the staff office to ensure people's confidentiality was maintained.

Records containing personal information were stored in the staff office which was adjacent to the main lounge and was not locked when left unsupervised. This meant that personal information was visible and accessible to people using the service and visitors, demonstrating that people's confidentiality was not always adequately protected.

During the handover on the first day, people in the lounge/ dining room were speaking amongst themselves and one person started talking to staff. One member of staff shouted at this person during telling them to "be quiet" before taking them by their arm and telling them to "go over there" in an abrupt manner. This member of staff then shouted at another person in the lounge area, shouting their name loudly and telling them, "I can't hear. Be quiet." This showed a lack of respect towards people, and an institutional approach that did not recognise the lounge/ dining room was a space that belonged to people and not staff. In addition other staff did not act to challenge this. We raised this with the manager to be explored as a potential safeguarding and performance issue. Following the inspection we raised this with the local authority.

During the handover on the first day, one member of staff was discussing a person who became agitated when staff completed checks on them during the night or tried to offer night time support. This member of staff tried to explore the causes for this, however another member of staff cut this discussion off and stated that the person was "naughty" and their behaviour depended upon which member of staff was supporting them. This was not a dignified way of speaking about people and showed a lack of insight into ways of effectively supporting people. We followed up with the person in question who demonstrated full insight and capacity into their needs. They told us they understood why staff checked on them during the night, but did not enjoy the frequency or like being woken up. This person's care record showed that no discussion had taken place with the person around this, or whether they had a preference for not being disturbed through the night. This demonstrated that people were not always given choice and control over their care.

This is a breach of Regulation 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always treated with dignity and respect and personal information was not kept confidential.

In other examples positive relationships had been developed between people using the service and staff. During the early morning we observed night-time staff speaking kindly and gently to people whilst carrying out checks to ensure people's wellbeing. We observed a member of staff expressing concern and acting to support one person who had been unwell. We also observed examples where staff and people were laughing and joking together. This demonstrated a more dignified approach towards meeting people's needs.

People's family members commented that they were made to feel welcome when they visited the service. Their comments included, "I pop in anytime, at mealtime they always ask 'Do you want to eat with us?'" and "They have a good relationship with relatives. We always feel welcomed". This helped ensure that people could maintain those relationships that mattered to them and prevented them from becoming socially isolated.

End of life care plans were in place for some people which outlined people's preferences regarding how they wanted to be supported in the event of their death. For example, one person's care plan stated that they wanted to remain at the service in the event of a decline in their physical health, unless they suffered a stroke or a fracture. Where people had chosen not to be resuscitated, the required paperwork was located at the front of their care record so it was easily accessible.

Requires Improvement

Is the service responsive?

Our findings

People told us they received the care and support they needed. Their comments included, "Staff know more about me than I do myself", and "Yes they give me the help I need". People's family members told us their relatives were well supported by staff.

Initial assessments had been completed for people prior to them moving into the service. These included information around people's physical and mental health, mobility and personal care needs. We observed that one person's initial assessment had not been fully completed to include information regarding their communication or cognition which we raised with the registered manager.

Initial assessments were used to inform long term care plans regarding people's care needs. In one example however we observed that a person did not have any care plans in place despite having complex health needs, being at risk of malnutrition and being vulnerable to developing pressure ulcers. We raised this with the registered manager who informed us that this person's care records were "A work in progress". We followed up on this person to ensure they were receiving the care and support they needed and found that referrals had been made to appropriate health professionals as required for support.

Other people's care records contained conflicting or insufficient information about their care needs. For example one person's daily notes made frequent reference to them waking through the night. However their night time care plan stated that they slept well. Another person's care plan stated that they were at low risk of falls; however they had had a number of falls over a two month period. One person's wellbeing was also being impacted upon by frequent night-time checks, however this person had not been consulted about this despite having capacity. In another example a person was documented as having episodes of confusion which impacted upon their communication. Alternative means of assessing this person's needs during periods of communication were not included. We also observed examples where nutritional risk assessments were not fully completed to ensure people were at a safe weight.

Care records were reviewed on a monthly basis. This process was meant to ensure that care records were up-to-date and accurate. However we were able to identify areas where information was not always complete or accurate. This showed that the review process was not always effective.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people's care had not always been designed or provisioned appropriately.

Daily notes were completed by staff which included a good level of detail about the care and support that had been given to people during the day and night. These outlined whether there had been any issues, and if so what action had been taken to address this. Professional communication notes were located at the back of people's care records which included clear information on input from health professionals. This provided a record of people's presentation which could be used to develop the care and support that was provided to them.

People commented that there were activities available for them to participate in if they wanted to. Their comments included, "There are plenty of activities but the choice is a bit limited" and "We could do with a bit more really". Other people commented that they had been on trips to the local garden centre, and there was a 'tea and chat' afternoon available for people to attend which people enjoyed. During the inspection visit we observed staff and people playing games and completing puzzles in communal areas. This helped to protect people from the risk of social isolation. We raised the comments made by people with the registered manager so that they could address these.

The registered provider had a complaints process in place which had been made available to people and their families. At the time of the inspection the registered provider had not received any complaints. People commented that they would feel comfortable approaching the registered manager with any concerns they may have.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who had been registered with the CQC since September 2014. People and their family members were aware of who the registered manager was and told us that they felt able to raise any concerns they may have with them.

At the last inspection in January 2017 we identified a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because audit systems were not robust and action had not been taken to address concerns. At this inspection we found sufficient action not been taken to improve audit and quality monitoring systems.

Audit systems were not effective. Care record audits had been completed but failed to address issues relating to inaccurate or incomplete information in people's care records. For example malnutrition risk assessments had not been fully completed in any of the care records. This meant that accurate information was not always available for staff.

The registered manager had completed an infection control audit on the 31 July 2017 which stated that hand washing facilities were available in each bathroom. We identified one bathroom was also without hand washing facilities. During the inspection we also identified three bedrooms in which the mattresses or beds were stained with urine, and one bedroom where the carpet was heavily stained. Whilst it was possible that these stains had occurred following the audit, this showed that adequate monitoring of people's beds and carpets was not being carried out.

A number of incidents had occurred within the service which demonstrated that the security of the premises was not adequate. A 'site monitoring audit' had been completed by the registered manager on the 31 July 2017, which stated that the security arrangements within the service were sufficient. This showed that the registered manager and registered provider had failed to recognise where safety improvements were required, failed to learn from accident/ incidents and failed to implement effective measures to prevent them from reoccurring.

Staff meetings were held on a routine basis. Records showed that the meetings did not always promote a culture of openness amongst staff. For example during the meeting on the 11 August 2017 the registered manager stated that an anonymous member of staff had been raising concerns with the CQC and local authority. The registered manager informed staff that if this continued it would be treated as harassment and the police would be involved. This was very poor practice as staff should be encouraged to report any concerns they may have to regulating agencies. The concerns received by the CQC had been valid and resulted in us bringing our inspection forward. The registered manager had not used team meetings as an opportunity to share the concerns with staff to help them learn and improve.

During one handover we observed a member of staff being prevented from making suggestions relating to one person's needs that might serve to improve their wellbeing, by a senior member of staff. This showed a poor culture within the service that did not promote openness. We raised this with the registered manager

for them to address.

These are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because quality monitoring systems were not effective.

A survey had been completed by the registered provider during which people and some family members had been asked about the performance of the service. This included staff approach, food, and laundry. This had given people the opportunity to raise any concerns, and enabled the registered provider to make changes based on the suggestions. The results of this survey had been shared with staff during a team meeting.

The registered provider is required by law to notify the CQC of specific events that occur within the service. As part of the inspection we reviewed those notifications that had been sent to us and found that this was being carried out as required.

The registered provider is required by law to display their rating within the service. During the inspection we found that this was being done.

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 9 HSCA RA Regulations 2014 Person-centred care Care had not always been planned or provisioned in line with people's needs. Adaptations had not been made to the environment, in line with best practice, to promote the wellbeing of people living with dementia.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider and registered manager's registrations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity or respect.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider and registered manager's registrations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider and registered manager had failed to adequately respond to known risks. People had been at on going risk of harm.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider and registered manager's registrations.

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 registered provider had failed to ensure that

	measure were in place to protect people from harm in line with the Mental Capacity Act 2005.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider and registered manager's registrations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audit systems were not robust or effective.

The enforcement action we took:

We issued a notice of proposal to cancel the registered provider and registered manager's registrations.