Northfield Care Centre (Thorne) Ltd

Northfield Care Centre

Inspection report

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Tel: 01405816042

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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

Northfield Care Centre is a '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.

Northfield Care Centre provides accommodation care and nursing care for up to 80 people. The home consists of four separate units, one providing personal care and the other three providing nursing care. Some people receiving support at the home were living with dementia. Accommodation is provided over three floors, with the upper two floors being accessed by passenger lift. On the day of the inspection there were 37 people living in the home and three people who regularly came for care during the day.

This inspection took place on 8 October 2018 and was unannounced. This meant the people who lived at the home and staff did not know we would be visiting. Our last inspection at Northfield Care Centre took place in April 2018 when the service was rated overall as requires improvement. At that inspection, we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in Regulation 12; Safe care and treatment and Regulation 17; Good governance. You can read the report from our last inspections, by selecting the 'all reports' link for 'Northfield Care Centre' on our website at www.cqc.org.uk.

During this inspection, we did not see sufficient improvement to warrant a rating of 'Good', which is the minimum standard care homes should be aiming to achieve for people who use their service. Due to the failure to improve, we have rated the service as 'Requires Improvement' for a second time.

We checked on progress with improvements the registered provider told us they would make in the action plan they sent to us after the last inspection. We found the registered provider had made some improvements. However, there were continued shortfalls and we found a repeated breach of Regulation 12, Safe care and treatment, in relation to people's medicines not being safely managed or consistently administered as prescribed. We also found further breaches in Regulation 12, Safe care and treatment, in relation to shortfalls in people's assessments and care plans regarding risks associated with their care, as well as in day to day monitoring records kept about people's care. We found a repeated breach of Regulation 17, Good governance in relation to the range of audits to monitor and assess the quality of the service. The registered provider had not been proactive, identified shortfalls or taken action to address them in a timely way. This had led to some risks associated with people's care not being addressed or managed effectively.

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

There was no registered manager in post at the time of the 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 a legal responsibility for meeting the requirements in the

Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered provider had appointed a manager who was employed at the home and was in the process of registering with the Care Quality Commission.

There were enough staff to support people safely. However, staff were often very busy, having limited time to engage with people. The home was clean and tidy and staff had received training on reducing the risk of the spread of infection. The manager was monitoring accidents and incidents and there was evidence that trends and patterns were being identified, and some actions had been taken to reduce hazards in relation to these.

Staff received ongoing relevant training. However, some staff had not received an adequate induction when first started working in the home, staff performance was inconsistently monitored and some staff said they felt unsupported. Most people told us they liked the food. Meals provided were nutritious and appetising. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, some assessments of people's capacity to make decisions and records about people's consent to care were incomplete, or required more detail.

Staff treated people with respect or dignity. We observed caring interactions when staff were supporting people. Although, the time staff spent engaging with people, other than to complete to day-to-day tasks, was limited. Efforts had been made to include people in making decisions about their day to day care, but records did not always reflect their involvement in ongoing reviews. People's religious and cultural needs were met, their independence was encouraged, People's confidentiality was respected and their records were handled in accordance with the Data Protection Act 2018.

People's care plans were not as person centred as they could be. The quality of people's end of life care planning documentation needed improvement. There were opportunities for people to engage in activities and the home also provided a dementia café and held events with guest speakers, which were open to the public. Most complaints were handled appropriately, although recent records showed some complaints had not been responded to in a timely way.

Although, a range of audits were in place and most of them identified areas of improvement, we found the audits in relation to medicine management and risk management were not effective, as they had not identified the concerns we raised during our inspection. Shortfalls in people's care plans and written records had not been identified. People, their relatives and staff were asked for their view regarding the service. However, the outcomes were not always fed back to people.

The registered provider's senior management team had been alerted to concerns about the quality of the service and had responded with increased level of senior management presence in the home. Members of the senior management team were aware of areas for improvement in audit and governance and were introducing new quality assurance systems, to improve in these areas. They were also reviewing the support available to the manager in the home, to ensure this was effective. There was evidence that shortfalls were being more effectively identified and improvements were being made. However, these improvements needed to be embedded into practice.

Further information is in the detailed findings in the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Risks associated with people's care were identified but not always managed effectively. Medicines were not always managed in a safe way.

Staff were available to keep people safe, but they were often very busy.

There was a system in place to safeguard people from abuse and the home was clean.

Is the service effective?

Requires Improvement

The service was not always effective.

People were given choices and staff were aware of current legislation. However, this was not always formally documented.

Although, staff received relevant training they did not always have an appropriate induction and their performance was not always monitored through regular supervision.

Most people said the food was good, and overall, people had appropriate access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff had limited time to spend engaging with people, other than to complete to day-to-day tasks.

Although, staff were careful to provide people with day to day choices, there was little evidence that people were involved in their reviews.

Staff were kind and caring and respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always person centred and did not always include information about how people liked to be supported.

The re were policies and procedures to ensure staff understood how to meet people's needs at the end of their life. However, some care plans were not detailed or clear enough about people's preferences.

Complaints were not always dealt with in a timely way.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered provider had some systems in place to monitor the service. However, audits had not highlighted the issues we raised at this inspection.

People, their relatives and staff were asked for their view regarding the service. However, the outcome was not always fed back to people.

Northfield Care Centre

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 took place on 8 October 2018 and was unannounced and was carried out by three adult social care inspectors. We brought the inspection forward because we received information of concern from visiting health care professionals and the local authority safeguarding and contracting teams, along with some concerns from relatives of people using the service about the standard and safety of care provided.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the manager and other information we received, such as from health and social care professionals and members of the public. The registered provider last submitted a provider information return [PIR] in October 2017 and as this was some months ago, we requested some updated information about this at the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with other professionals supporting people at the service, to gain further information about the service.

On the day of the inspection we spoke with six people who used the service and four visiting relatives. We spent time observing staff interacting with people. 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 reviewed the areas identified for improvement and in breach of regulation at the last inspection, including the systems used to manage people's medication. We looked at the quality assurance systems in place to check if they were robust and identified areas for improvement.

We spoke with 10 staff including care workers, senior care workers, nurses, catering staff, an activity co-ordinator, the deputy manager and the manager. We also spoke with three members of the provider's senior

management team, including the operations manager and two area managers.

We looked at documentation relating to people who used the service, staff and the management of the service. We looked at five people's care and support records, including the plans of their care. We looked at records of complaints. We reviewed personnel records for 10 staff including one bank staff and the information provided to the home regarding the training and experience of five agency staff.

We also reviewed several quality questionnaires the provider had asked people had completed to feedback their views of the service. This included four from people who used the service, four from people's relatives, five from visitors and 11 from staff.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2018 we found the provider was in breach of regulation in relation to the management of people's medicines.

At this inspection we found there remained a need for improvement. In the residential part of the service there had been a lack of management oversight of the way people's medicines were being managed in recent months. For instance, external health care professionals had recently identified that a quantity of one person's medicine, used to treat anxiety, was unaccounted for. Due to a breakdown in communication in the senior team, no proper investigation was undertaken at the time. We discussed the shortfalls with the management team and they provided us with evidence, after the inspection, that appropriate remedial action had been taken to address this issue and to prevent further, similar occurrences.

We identified a need for a more formal system to ensure that people received any time sensitive medicines at the correct times. Time sensitive medicines should be taken, for instance, before or after food, or not at the same time as other medicines.

We found in most cases that medicines were recorded, administered and stored in accordance with instructions and a new deputy manager had been employed who was a qualified, experienced nurse. They had taken on the role of clinical lead. A clinical lead is a senior nurse who oversees nursing staff in a service to ensure high quality nursing care is delivered to people. At the time of the inspection the clinical lead had been in post for two weeks and had made some improvements in the way medicines were managed for people who received nursing care. However, there was a need for the improvements that had been undertaken to be embedded in to practice.

The evidence above indicates a repeated breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12, in that the management of medicines was not always effective.

We looked at the way risks were managed and found that most risks associated with people's care had been identified. However, guidance about the action staff should take to manage the risks was not always in place to ensure people's safety. For instance, people had personal emergency evacuation plans (PEEP's) in place to identify the assistance they required in the event of an emergency, these were very generic and did not always specify how the person should be supported in the event of a building evacuation when they used equipment such as wheelchairs.

Some people's moving and handling risk assessments and care plans did not contain all the required information to ensure people were moved safely. For example, one person's records showed the person used a stand aid with a sling. A stand aid is equipment designed to aid those who have difficulty getting up into a standing position. The person had two care plans in place that referred to their use of the stand aid. However, the plans gave no detail about the size or type of sling. The sling included loops and there was no detail about the loop configuration to be used.

Monitoring records did always not contain sufficient information to ensure people were cared for appropriately and safely. For example, Positional change charts had been completed by staff to show the times one person was supported to reposition in bed. The charts did not include how often the person should be supported to reposition. Therefore, it was difficult to judge if the person had received appropriate care. The person's records also indicated that a topical cream, used to moisturise and protect their skin, should be applied twice a day. However, the written record completed by staff showed the cream was being applied once a day. There were also gaps in the record.

Food intake monitoring charts were not completed in sufficient detail to monitor if people were receiving adequate nutrition. Fluid intake charts, did not include the amount of fluid the person needed in a 24 hour period. This made it difficult for staff to know the amount of fluid they should aim to provide the person with, or at what point they should make senior staff aware if the person was not receiving the appropriate amount. Some recording errors had been overwritten, so it was difficult to monitor what had to drink and the records had not been completed consistently. For instance, one person's records indicated more than one 24 hour period when they had a drink for 16 hours, from early afternoon, until the following morning.

The evidence above indicates a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12, Safe care and treatment, in that risks associated with people's care were not always effectively managed to keep people safe.

There were enough staff to support people safely; however, there was feedback that staff were often very busy, having limited time to engage with people. Before the inspection we had received concerns from people's relatives, staff and other professionals about a lack of staff to meet people's needs in a timely way. At the inspection around half the people we spoke with said there were usually enough staff. However, some people and their relatives who told us there were shortfalls in staffing. For instance, one person told us the service had deteriorated in recent months and they often experienced long waits. They told us some staff were quite curt and said they were too busy to provide the person with care when they needed it. We discussed this with the management team and they provided us with evidence, after the inspection, that appropriate remedial action had been taken to address the person's concerns.
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Concerns about staffing levels had featured in some recent provider quality questionnaires complaints. For instance, one relative wrote, "Staff seem to be rushing about/unable to spend time with residents". We spoke with the manager about people's concerns about staffing. The manager told us that a group of people, who were living with dementia had recently been moved to the top floor of the home. After people were moved, it had become clear this had taken place without enough planning regarding the impact on staffing needs. The manager told us this had led to concerns being raised about staffing in recent weeks. The manager provided evidence that this issue had been addressed and things had improved as a result.

Some people had also expressed concern that high levels of agency staff were being used as they were not familiar with people's needs. For instance, one person's relative said staff were always changing and this affected the consistency of care to their family member. We discussed this with the management team. The area manager told us assessments of people's needs were carried out to ensure that the appropriate number of staff were in place to support people safely. From our observations, we found that overall; there were enough staff to support people. People received the support they needed with their meals and with moving around the home and staff responded in a timely way when people needed or requested their support. However, the focus of the staff was predominantly task-led with little time left for engagement that was more meaningful.

Members of the management team explained they had experienced some difficulty in recruiting suitably

trained and experienced staff, particularly nurses. They told us a new deputy manager had been employed who was a qualified, experienced nurse and that this would help to reduce the need to use agency nurses. Senior managers told us they were aware it had taken too long to fill staff vacancies and in response, they had made changes to the recruitment process to support the manager and to reduce the time it took to recruit new staff. In the meantime, wherever possible, the same agency staff were used, to help maintain as much consistency as possible. Most people and their relatives we spoke with said there were enough staff, but there remained a small number who said they had yet to feel the benefit of these recent improvements.

The registered provider had a recruitment policy which assisted them in the safe recruitment of staff. This included obtaining pre-employment checks prior to people commencing employment. These included references from previous employers, and a satisfactory Disclosure and Baring Service check (DBS). The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. We looked at three staff recruitment files and found they contained the relevant checks.

The Nursing and Midwifery Council (NMC) is the regulator for nurses and midwives in the UK. Nurses must register with the NMC and upon registration, are given a unique identifying number called their pin. The registered provider completed regular checks to ensure nursing staff employed at the service maintained their professional status and NMC pin numbers.

The registered provider had a system in place to safeguard people from the risk of abuse. Staff we spoke with told us they received training in safeguarding. Staff were knowledgeable about how to recognise and report abuse and would action any concerns without delay.

We found all areas of the home were clean and staff were trained and followed good practice in the prevention of infection, using personal protective equipment (PPE) such as gloves and aprons when needed. Accident and incident analysis was taking place, including in relation to falls, although the information was presented in a way that made it difficult to monitor if there were trends and patterns.

Requires Improvement

Is the service effective?

Our findings

We received mixed views from staff we spoke with about the quality and type of training they received and saw that in the staff survey some staff had highlighted shortfalls in the induction process. For instance, when referring to the induction training, one staff member had written, "I was left to my own devices", while another staff member said they did not receive an induction and had had been part of the planned staffing from their first day, without any period of introduction to the home.

The monitoring record kept in the home of the training staff had received showed that training was provided in the core subjects, such as moving and handling, fire awareness, and infection control, as well as areas related to the needs of people using the service, such as pressure care, nutrition and end of life care. However, feedback from some people who required nursing care, their relatives and other professionals showed people had not always received support from staff who had the training to meet their specific and specialist needs. For instance, we were told of people who had been admitted to the home prior to staff having the necessary training and that the necessary training, or updates had not been provided to staff in a timely way.

Staff performance was not always monitored through regular supervision. Supervision is a regular one to one meeting between the supervisor (line manager) and supervisee to meet organisational, professional and personal objectives. Supervision forms a key part of individual performance management and for newly appointed workers, it underpins the staff induction process. We also noted that some staff questionnaires, completed by staff to feedback their views to the provider in recent months also included concerns about a lack of support.

Some staff we spoke with told us they did not receive regular supervision sessions and felt unsupported. Records we saw confirmed this. For instance, from looking at staff personnel files we saw that one nurse and one care worker had been employed since March 2018 and there was no record of them having received any formal supervision, induction meetings or probationary reviews. In addition, the record kept by the manager to monitor when staff had received supervision did not include staff members' start dates, making it difficult to know if staff had received the appropriate support, in a timely way. This record indicated that almost half of the staff employed had not received any supervision during 2018. We discussed the shortfalls in staff supervision with the manager, who told us it had been difficult to fulfil their management responsibilities, due to a shortage of staff, particularly trained nurses. They added that now the deputy managers were in post this would make it possible for staff supervision to be undertaken on a more regular basis.

We found some instances where people had been admitted before the necessary equipment was in place, or whose care plans were not completed in a timely way, after admission. For instance, we were told of one person who was admitted before a bed that suited their needs was provided. Another person had not had care plans in place regarding areas relevant to their care, including the management of their pain, some months after being admitted. However, for the most part, arrangements were in place to assess people's needs and choices and the assistance people required was established before they were admitted. This included establishing if people had cultural or ethnic beliefs that affected the gender of staff from whom

they wished to receive personal care. Initial assessments showed any additional provision needed, such as specialist equipment.

Overall, people were supported to have access to healthcare professionals and to receive ongoing healthcare support. We looked at care records for people and found they reflected the support they received. People had access to healthcare professionals such as district nurses, GP's, palliative care nurses and physiotherapists. However, we found that one referral had been made for one person regarding services from continence specialists some months previously and there was no indication if the person had received input from the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act required that, as far as possible, people make their own decisions and are helped 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 people lack mental capacity to take 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 he service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of their liberty were being met.

We looked at documentation and found that DoLS had been submitted, some had been approved and others were awaiting assessment. The care plans did not show where people were in the assessment process. We saw where people lacked capacity staff had considered best interests. For the most part, information about people's cognition had been documented in sufficient detail. However, this was not the case in one person's care records we saw and records about their consent to care were incomplete.

People received a healthy, balanced diet which met their needs. We spoke with catering staff who were aware of people's likes and dislikes. Catering staff were also knowledgeable about people's diets and any individual requirements were catered for. There was evidence that people had a choice of meals, as they were asked to select choices from the menu, so their choices could be prepared. Most people we spoke with said the food was good. However, some people felt there could be more variety in the menu, particularly at teatime.

Care staff we spoke with told us they had received training about nutrition and demonstrated that they understood the importance of promoting people's well-being through good nutrition and hydration. We saw that staff were very calm and patient when delivering meals. People were offered a choice of food for lunch and their preferences and choices were respected.

Requires Improvement

Is the service caring?

Our findings

Although staff shared friendly and appropriate banter with people and they responded in a positive way, the time staff spent engaging with people, other than to complete to day-to-day tasks, was limited.

Although, staff were careful to provide people with day to day choices and ask people their opinions, there was not much written evidence that people or those close to them were involved in making decisions about their care to ensure their needs and wishes were being met. In addition, some relatives we spoke with told us they had not been involved in any reviews of their family members' care after they were admitted to the home and had not seen their family members' care plans.

We observed staff interactions with people who used the service and found they were kind and caring in nature. We spoke with people who used the service and their relatives about the care and support provided. One person said, "I am very happy with the care I receive and some staff are great, others not so, but they all care and I am well looked after." One relative felt that care and attention was given to their family member and said, "Carers are welcoming and friendly, [relative] gets on well with the staff here."

We saw staff chatting to one person who had recently celebrated their birthday and one staff said, "You were 90 years young," which the person found amusing and they laughed. One person was helped into the dining room by two care workers and commented, "These girls are great, they are very good helpers." One care worker assisted another person to the dining table and helped them sit where they could see out of the window. The care worker said, "I will open the net curtain a little, so you can see the trees better." The person smiled and showed they were content looking out of the window.

Staff showed compassion towards people if they became distressed. For instance, we saw that one person became quite upset and staff sat with the person and made conversation, trying to ascertain what the problem was. Following their conversation, the person appeared much happier. Another person said, "Oh I have got pins and needles in my hands again." One care worker said, "Move your fingers like this," showing the person how to relieve the feeling they were experiencing.

People told us staff encouraged them to be as independent as possible and we saw people were encouraged and supported to carry out some daily living tasks. The staff we spoke with were committed to providing care and support which ensured people's privacy and dignity were maintained. One staff member said, "One person becomes embarrassed when we deliver personal care. I find that it's important to explain what is happening. It is important to look at people's eyes and body language to gauge how they are feeling."

Meeting people's religious and cultural needs was part of people's plans of care. Staff recognised that different religions had certain customs that needed to be respected. Staff were aware of people's beliefs and ensured people were appropriately supported. People were also supported to maintain relationships with those who were important to them, such as family members and we saw that people's visitors were welcomed by staff in a friendly manner and there were no restrictions on peoples' friends or families visiting

them.

The management team protected people's rights in relation to how information about them was kept and used. For instance, the provider promoted awareness in the staff team about recent data protection legislation. People's right to privacy and confidentiality was promoted by staff and people's written and electronic information were securely stored. When staff discussed people's care needs with us they did so in a respectful and compassionate way and they were aware of issues of confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Care records were not always person-centred and did not always include information about how people liked to be supported. For example, although we saw people had a 'preference questionnaire' in place to indicate their choices such as how they would like to be addressed, this information had not been included in individual care plans to ensure staff were aware of people's choices.

There were had policies and procedures in place to ensure staff knew how to support people at the end of their life. However, some people were receiving end of life care, but they did not have individual end of life care plans in place. We spoke with the management team who told us this had been identified by them as an area for improvement and they were addressing this.

Most complaints had been addressed appropriately. However, some records we saw of recent complaints showed they had not been responded to in a timely way. We discussed this with the manager who told us they had been away on leave. In future, in their absence, the deputy managers would respond to people's concerns. People and their relatives knew how to complain and they told us they would inform the management team if they were unhappy with their care. However, some people and their relatives added that recently, staff usually looked too busy, and we noted that one relative had commented in their quality questionnaire, "Never can find anyone senior. Can feel as though everyone is too busy to discuss our concerns at times."

The activity co-ordinator was available 35 hours a week. Their role was to organise and deliver social stimulation within the home. The activity co-ordinator told us they worked flexibly to meet the needs of people who used the service. We saw a monthly newsletter was published to inform people what events were taking place and people who were celebrating a birthday or special occasion. The service offered regular activities such as coffee mornings, bingo sessions, parties, and trips out. The home also provided a dementia café which was open to the community to join in. This included guest speakers.

Although we were told that one to one social activities were provided for people who preferred to stay in their rooms, people we spoke with had varying views regarding activities provided. One person told us they would like someone to help them write a letter and said, "The activity co-ordinator is good but they are spread too thinly and don't have much time." One person's visiting relative felt there was not much social stimulation for their family member, who was mainly cared for in bed. Whereas, one person said, "[The activity co-ordinator] comes and chats to me in my room and I like that company."

Families and friends were welcome to participate in activities and people we spoke with told us they enjoyed socialising together. The service welcomed support from the wider community and had four volunteers who helped provide activities within the home and who assisted people on trips out. The service made good use of social media and with consent, used this to demonstrate what activities had taken place. This had been particularly useful to families who were unable to visit the home as frequently.

The home had some contacts with religious groups who visited and spent time with people who wanted

this. A priest visited the home regularly to offer religious support to people. At the time of our inspection the activity co-ordinator told us there was nobody currently living at the home who had expressed an interest to attend church services. However, they told us this would be accessed if required.

Requires Improvement

Is the service well-led?

Our findings

It is a condition of registration with the Care Quality Commission (CQC) that the home has a registered manager. However, at the time of our inspection there was no registered manager employed at the home. 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 registered provider had appointed a manager who told us they were in the process of registering with the Care Quality Commission. However, we had no record of an application having been made.

At our last inspection in April 2018 we found a breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17; Good governance. This was because the audits to monitor and assess the quality of the service were not fully effective. The registered provider had provided us with an overarching action plan following our last inspection, showing action they would take to address the issues we identified at that time. However, at this inspection, we found further shortfalls. There was continued evidence that shortfalls had not been consistently identified, or where they had, they had not been effectively addressed.

There had been no effective system to support senior managers to maintain good oversight of the day to day management of the home. The registered provider had not been proactive, identified shortfalls or taken action to address them in a timely way. This had led to some risks associated with people's care not being addressed or managed effectively.

Progress with audits and action plans had not been effectively overseen. Audits had failed to identify shortfalls in people's care plans and risk assessments. Monitoring records about repositioning and food and fluid intake were not always kept appropriately. Although there was evidence these records were checked by senior staff, there was no evidence the shortfalls we saw were addressed, to ensure the person was receiving appropriate care. Not everyone's records were complete in relation to consent to care or the Mental Capacity Act 2005. People's care plans were not sufficiently person centred. New staff had not been recruited in a timely way to and existing staff had not received adequate professional support through supervision.

There had been a lack of oversight of the way people's medicines were being managed and those medication audits that had been completed had not identified the issues identified at this inspection. This also indicated that some remedial actions included in the action plan sent to us had not been undertaken consistently or effectively.

People, their relatives and staff were asked for their views regarding the service using written quality surveys, and for the most part, the results were positive. However, some responses identified areas for improvement, but we saw no evidence that this feedback was, included in any improvement plans used to improve the service. Several comments had been made regarding staff not having time to meet people's needs, both via

the survey and via the registered provider's complaints process. We also noted that some staff questionnaires included concerns about a lack of adequate induction into the home and a lack of management support. We saw no evidence that these themes had been considered by the senior management team and outcomes were not always fed back to people.

In recent weeks, the registered provider's senior management team had been alerted to concerns about the quality of the service and, at the time of the inspection they had responded, with increased level of senior management presence in the home. Several members of the senior management team attended the inspection. We were assured that the team were aware of areas for improvement in audit and governance and were introducing new quality assurance systems, to improve in these areas. They were also reviewing the support available to the manager in the home, to ensure this was effective. There was evidence that some shortfalls were being more effectively identified and improvements were being made. However, these improvements needed to be embedded into practice.

This was a repeated breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17; Good governance in that the audit systems in place did not effectively identify or address areas for improvement in the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure (1) Care and treatment was provided in a safe way for service users. (2)(a) that the risks to the health and safety of service users of receiving the care or treatment were properly assessed; (b) that all that was reasonably practicable was done to mitigate any such risks The registered person did not ensure (1)(2)(g) the proper and safe management of medicines.

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 17 HSCA RA Regulations 2014 Good governance The registered person did not always ensure (2) Effective systems or processes were always in place to enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete 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 provided.

The enforcement action we took:

Issue warning notice.