Silver Healthcare Limited

Fulwood Lodge Care Home

Inspection report

379b Fulwood Road
Ranmoor
Sheffield
South Yorkshire
S10 3GA

Tel: 01142302666
Website: www.silver-healthcare.co.uk

Date of inspection visit:
12 December 2016

Date of publication:
30 January 2017

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 took place on 12 December 2016 and was unannounced. This means prior to the inspection people were not aware we were inspecting the service on that day.

Fulwood Lodge is a 42 bed home providing personal and nursing care to older people with a range of support needs, including people living with dementia . It is located in the Ranmoor suburb of Sheffield. On the day of our inspection there were 33 people living in the home.

The manager had worked at the service for nine months and had not completed their registration with CQC. 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.

Our last inspection at Fulwood Lodge took place on 9 November 2015. The home was rated as Requires Improvement. We found the home to be in breach of regulations for safe care and treatment and person-centred care. Requirement notices were given for these breaches in regulation and the registered provider was told to make improvements. On this inspection we checked improvements the registered provider had made. We found there were still breaches in regulations, therefore sufficient improvements had not been made to meet regulations.

Risks to people were not being managed effectively so that people were protected.

People's safety was being compromised because action had not been taken following the recommendations of the fire risk assessment.

There was no system in place to assess staffing levels against people's needs. Our observations evidenced there were not enough staff on duty at certain times.

In staff files we found gaps in the information required to ensure people being employed were of good character.

Staff were trained to give people their medicines in a safe way. Medicines were administered, stored and recorded as per recommended guidelines.

Staff were not given appropriate support through a programme of regular training and on-going supervision and appraisal.

A planned programme of social activities was not in place. An activity worker had been recruited and was due to start at the home within the next few weeks.

The manager investigated and responded to people's complaints, according to the provider's complaints procedure.

We identified the current audit systems were not robust enough to effectively assess, identify and act upon, risk and improvements required at the service, in order to demonstrate compliance with regulations.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in; Regulation 12; Safe care and treatment, Regulation 18; Staffing, Regulation 19; Fit and proper persons employed, Regulation 10; Dignity and respect, Regulation 17; Good governance. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore 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 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 recommendations made in the fire risk assessment had not been actioned which could place people at risk of harm.

Staffing levels were not adequate to meet the needs of people who used the service.

Procedures for recruiting staff were not thorough which did not ensure people employed were suitable.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supported through a regular programme of training, supervision and appraisal.

People's views about the quality of food and meals was mixed.

The service was meeting the requirements of the Deprivation of Liberty Safeguards. Staff had an understanding of, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always take into consideration people's privacy and dignity when providing care and support.

People's confidentiality was not always maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was very little planned social activity available to people.

Some relatives and friends were involved in making decisions about their family member.

People knew how to make a complaint if they were unhappy.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and audit the service were inadequate and did not ensure people who used the service were safe and received a service which met their needs.

There were quality assurance and audit processes in place, but these had not been effective in ensuring compliance with regulations and identifying areas requiring improvement and acting on them.

Fulwood Lodge 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 December 2016 and was unannounced. The inspection team consisted of two adult social care inspectors 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. The expert by experience had experience in caring for older people and people living with dementia.

In order to understand what peoples experience was of living in the home we carried out a SOFI in a lounge/dining room area of the home. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the visit we spoke with five people who used the service, five relatives and one friend, the manager, four care workers, one domestic assistant and the cook. We also looked at four care plans, four staff files and records associated with the monitoring of the service.

Prior to the inspection we contacted people who had an interest in the service. We received feedback from a Sheffield local authority commissioners and safeguarding.

Inadequate

Is the service safe?

Our findings

People told us, "I like it here. The staff are smashing. They make me feel safe," "I can't complain, the staff make sure I am safe," "You sometimes have to wait for things when they are short staffed," "I get fed up of waiting, staff say they will do it in a bit, but then don't" and "Staff do as much as they can for you but sometimes at the weekend there aren't enough staff."

Not all relatives were confident their family member was safe and well cared for. Relatives told us people were not always supervised as sometimes there were not enough staff. Relatives were clear they would speak to someone if they were worried or had any concerns although they said they did not all know the manager very well.

Relatives told us, "I am confident my relative is safe at all times," "We are so happy we chose this place for mum, she is so much safer," "I feel [family member] is safe here, they do all they can for her," "If they are short staffed [relative] has to wait a long time for them to answer the buzzer," "I would not hesitate reporting safety matters to the manager," "When I come at 11.30am they sometimes have not had time to get [relative] up so staffing numbers is an issue" and "The staff have been brought in off another floor to get people up, washed and dressed."

On the day of the inspection there were 33 people living in the home. There was the manager, two nurses, four care workers, a cook, a kitchen assistant, two domestic assistants, a laundry worker and the maintenance worker. The manager told us there would normally be five care workers on during the day but one staff had phoned in sick and they had not been able to replace them. When we spoke with staff they told us there were not enough staff on during the day in order to make sure people's needs were always met. Staff told us, "The staff numbers have been reduced and there's a lot of sickness which just makes it worse," "We should have six care workers on but today there is only four and it's been the same on other days," "Short staffing is killing morale. We're just running from one person to the other responding to buzzers" and "We find ourselves cutting corners, like not using hoists or giving up feeding people because it takes too long."

During our SOFI observation we saw staff were all very busy, attending to people's needs and providing people with food and drinks. Staff were very task orientated and did not have time to spend with individuals. We saw people asking to be taken to the toilet and asking for drinks and although staff tried to respond to them, people were left to wait for varying periods of time until staff were free. For example one person's hot meal was put in front of them and it was ten minutes before a staff member came to assist the person to eat. By this time the meal was cold. We heard another person say, "Well I'll just have to do it here because you can't take me to the toilet."

Of the 33 people living in the home 26 people needed two staff to assist them to move and the majority of people needed assistance to eat. As the home had communal sitting and dining areas on two floors, this meant on the day of the inspection there was one nurse and two care workers on each floor.

The manager told us they had recently reduced staffing numbers due to there being fewer people living in the home. We asked what 'tool' they had used to assess this and were told they hadn't used any 'dependency tool' but carried out the instructions from the provider to reduce staffing levels. We looked at the staffing rota's for the home and found staffing levels on some shifts had fallen below the number of staff on duty on the day of the inspection.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

At the last inspection on 9 November 2015 we found there was a risk that people who required wound care and/or assessment may not receive appropriate care and support to meet their needs.

Local commissioners of services contacted us prior to this inspection, in response to our request for information. One healthcare professional told us they had referred a person to safeguarding following a visit to the home when they had been concerned regarding the care provided to the person in relation to pressure care.

During our inspection we observed one person who remained in their wheelchair throughout the day. We looked at their care plans and found a 'mobilising' care plan stating "Needs to be re-positioned to relieve pressure areas." Staff spoken with told us the person was usually transferred into an easy chair but this had not happened because they had been too busy. The manager confirmed the person did not have any pressure wounds. We saw the person had a pressure relieving cushion in their wheelchair, however the risk of the person acquiring pressure wounds due to not being repositioned throughout the day meant the person was not receiving safe care and treatment.

A fire risk assessment was completed on 2 March 2016 by an external professional. Actions that had been highlighted as areas in need of particular attention included : doors requiring to be kept open should be fitted with automatic release devices and further fire drills are required to ensure staff know their roles and responsibilities in regard to evacuation. When we arrived for the inspection we found the majority of bedroom doors were wedged open with chairs, bags and ornaments. The doors were not fitted with automatic release devices. We asked the manager to make sure doors that were wedged open were closed, but throughout the day we observed staff replacing wedges to prop doors open. We asked for the records of fire drills. The manager told us they had not conducted a fire drill since they had started working at the home nine months ago. No records of any fire drills completed could be found. This meant people could be put at risk of harm.

We found assessments had been undertaken to identify some risks to people who used the service. These included environmental risks and other risks related to the health and support needs of the person. For example, some people presented a risk because of their limited mobility. We found the risk assessments in place were not always sufficient to protect people. For example a pressure area chart recorded a number between one and five, depending on which statement was most accurate. For example, zero being fully mobile and five being chair bound. From this the overall score for the person was calculated. However there was no information for staff about what this meant in terms of the degree of risk the person was at. Staff we spoke with were unclear about what these risk assessments meant and said it was the nurses who completed them. This meant staff could be unaware if a person had become more at risk from such things as pressure wounds and falling.

We found incidents and accidents were recorded and analysed by the manager each month. The analysis from September 2016 showed one person had fallen twice from their wheelchair after releasing their safety

belt. The actions the manager had recorded were, "Not to be left unattended." In October 2016 the person had loosened their safety belt and fell to the floor three times. The managers analysis recorded, "Staff once again advised not to leave [name] unattended." There was no further information about what actions should be taken to keep the person safe. When we looked at the person's care plan we found other healthcare professionals had been contacted and were providing advice to the staff, regarding the person's mobility and falls. During our inspection we observed times when people who used the service were left unattended in communal areas. This meant the management of accidents and incidents was not helping to ensure people were kept safe.

This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

We checked four staff personnel files to see if the recruitment of staff was safe. We found one staff member did not have any references on file and another staff member only had one reference. The manager told us they would look for these as they were sure they had been acquired, however the manager was unable to find them. None of the files seen had information confirming a Disclosure and Barring Service (DBS) check had been completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. The manager told us DBS information was kept separately at head office and they were unable to access this as the administrator was on annual leave. We asked the registered provider and manager to provide us with this information the day after the inspection. Following the inspection the manager sent us information that stated they had been unable to find evidence that five members of staff had completed a DBS check. We asked the manager to inform us of what action they were taking in response to this. The following day the manager confirmed they had acquired DBS information which confirmed two of the staff had completed a DBS check. The manager told us the remaining three staff who it could not confirmed had a DBS check would be working under the supervision of other staff until one was completed.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

The provider had policies in place regarding safeguarding and whistle blowing. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. Staff spoken with had an understanding of their responsibilities in keeping people safe. However, we found out of 18 care workers employed only four had received safeguarding training within the last year. Safeguarding training for five nurses and all ancillary staff (six) was also out of date.

At the last inspection on 9 November 2015 we found some people's medicines were not managed safely, so they were not protected against the risks associated with the unsafe use and management of medicines. At this inspection we found medicines were being managed in a safe way.

One person told us, "I get all my medication on time and if ever I need extra pain relief during the night it is never a problem." A relative said, "[Family member] takes regular pain killers and he always gets them on time when I am here and I visit at different times."

Qualified nurses were responsible for medicines administration. All nurses were trained in medicines management and had their competency checked by the manager each year. We observed a nurse administer medicines during the morning. Medicines were administered from a trolley, put into a medicine pot and taken to each person. People were offered a drink and the nurse sat with them until they were sure

the medicine had been taken. The nurse then signed the Medication Administration Record (MAR) to confirm as given. We looked at the MAR and found all medicines had been signed for or a code used to explain why the medicine was not given.

A small number of people took Controlled Drugs (CD's). CD's are medicines that require extra checks and special storage arrangements because of their potential for misuse. These were kept in a CD cabinet and recorded in a CD register. We checked the CD's given to three people. Each medicine had been signed as given by two staff and recorded the date and time of administration. A running tally was kept of each medicine which was checked and correct. We saw any medicines required to be kept in a refrigerator were stored in the medicine refrigerator in the treatment room. We saw the nurse on duty each day checked the refrigerator was within the required temperature range and then signed to confirm this.

Since the last inspection the registered provider had employed a full time maintenance person who was responsible for completing checks on such things as fire fighting equipment, emergency lighting and bed rails. We looked to see if these had been completed and found they had.

Inadequate

Is the service effective?

Our findings

We looked at the staff training matrix which showed the training staff were expected to complete within identified timescales. Staff had completed training in subjects such as moving and handling, infection control, health and safety and first aid. The training matrix confirmed to us that staff training in subjects the provider stated as mandatory, had not been provided within the providers timescales. For example, 12 staff had not completed training in moving and handling within the last year and six of 34 staff had completed training in nutrition in the last two years. Staff files seen confirmed they had completed a programme of induction at the start of their employment.

The provider's supervision policy stated staff would be provided with supervision at three monthly intervals, which would give them a formal opportunity to talk with the manager. Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. We found out of a total of 39 staff, three members of staff had been provided with four supervision sessions, 26 members of staff had received between one and three sessions and 10 staff had not received any supervision within the last 12 months.

Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles. There was no evidence that any staff member (except one) had received an annual appraisal since the manager had started in post on 1 February 2016. The manager told us they had not completed any appraisals due to them only working at the home for the last nine months. The supervision/appraisal matrix showed that no staff from a total of 37 had received supervision and appraisal as per the provider's policy. This meant staff did not have effective support through regular supervisions and appraisals.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

People gave mixed feedback about the food on offer. Some people complimented the food, others felt it was sometimes cold and did not look pleasant in presentation. People's comments included, "The food is alright," "I'm alright with what I get," "Sometimes it's cold, they just slop it on the plate" and "I enjoy the food and they know my preferences."

Relatives told us, "Mum never complains about the food," "Get rid of the frozen food," "Good presentation goes a long way, that's all that's wrong with it," "I would call it good food ruined," "Please could they have less frozen food products," "Sometimes they give [name] a really big plate of food, he hates it because he likes small portions," "If [name] does not sit at the table most of the food ends up on the floor" and "Some people have to wait a long time for their meal when they are short of staff."

A staff member said, "Nobody has told me the relatives are not happy with the food. I did not know a survey had taken place."

During breakfast people were seen to be waiting a long time for their meal and then never left the table until the lunch time meal was served. Where food had been dropped on the floor by people not sitting at a table this was not cleaned up straight way which meant the carpet was stained. This did not ensure a pleasant environment.

During the lunchtime meal we observed the menu on display was difficult to read. It was hand written on a black wall board in very small and indistinct handwriting. We asked people if they could read it but no one was able to.

The staff were seen trying to be calm and patient when encouraging people to the dining tables. This was observed to be a chaotic atmosphere. It was a busy time for the staff. A manager from another home was helping out in the dining room, assisting people to eat and guiding staff. This was not a regular arrangement but was because the provider had asked the manager to come to the home to support the home manager during the inspection.

The menu board offered two choices of main meal. However very few people were asked what they would prefer to eat. The drinks were pre-set on the tables, all of the same flavour. Extra drink was offered by the visiting manager to various people. At the end of the mealtime many drinks were left in the glasses. The staff gave meals to a number of people in the lounge areas that were adjacent to the dining area. This was not a calm experience for people living with a variety of mental health problems.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Four people who used the service had a DoLS authorisation in place. This was because they did not have capacity and could not consent to the care being provided to them due to their dementia. The DoLS authorisations for these people were for 12 months and would then be reviewed. The manager had also applied for DoLS to be authorised for another 13 people. The local authority had contacted the manager to explain there was a delay on authorisations but they would assess these over the next few months. The manager said they had been told any urgent authorisations they requested would be prioritised and put in place quickly.

The majority of nurses (with the exception of one) had received training in MCA and DoLS and those spoken with had a good understanding of this. Other staff we spoke with had a basic understanding of this and we found most care workers had not received any updated training in this subject.

Requires Improvement

Is the service caring?

Our findings

Two people who used the service were on end of life care. One had only returned home from hospital during the early hours on the day of the inspection and staff were in the process of completing their end of life care plan. We saw information to confirm discussions with other healthcare professionals and the person's family had taken place to agree the care and support required for the person and how this would be delivered. We observed staff regularly attending to the person and saw they looked clean, comfortable, pain free and well cared for. We observed when staff were attending to people in their rooms they left the doors wedged open which did not promote the person's dignity or privacy and meant we also heard information about the person that should have been confidential.

During the morning of the inspection we found personal records, for example care plans had been left on a trolley in a communal area. We asked the manager to move the files to a place where they would not be able to be seen by people living in or visiting the home.

This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

We asked people what they thought about the staff. They told us, "The staff are alright, they look after me," "They know just what I like," "There are two particular staff that I love, my key workers" and "The night staff are alright, they come as soon as I call them."

Relatives told us, "[Name] goes to bed exactly when he wants, he also gets up when he wants if there are enough staff," "The staff work so hard to keep [relative] happy," "If he has had a bad night he gets to lay in, the night staff communicate this," "The staff here are absolutely marvellous," "'Staff can talk at residents sometimes and not with them," "I come every day so I get a good idea of what's going on, the staff are great" and "[Staff name] is really special, she did everything to help my mother settle in. Mum loves her."

Staff and people who used the service looked comfortable together and there was a laughter and friendly 'banter' between people. People said they got on well with staff. Relatives and visitors were also welcomed in a friendly manner. One formal visitor stated they had not been informed that a person they visited had passed away. They said, "It was clearly stated in the care plan that I or [name] was to be informed. This did not happen. I felt so sad that I was informed the day I came to visit them."

Although we saw staff being kind and compassionate they were not provided with the direction and leadership required to ensure people received a consistently good standard of care. We saw a variation in the quality of support provided to people who required assistance from staff to eat their meals and be assisted to move around.

Some people had chosen to complete information and discuss with staff details about their personal preferences during the last stages of their life and we saw these in people's care plans. We also saw some people, with support from their relatives and their GP had been involved in discussions about resuscitation.

People's wishes had been recorded on Do Not Attempt Resuscitation (DNAR) forms which were also kept in their care plans.

Information about how people could access advocacy services were seen on display in the home so that people had access to this important information.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us, "I wish we could have more to occupy us," "It does get very boring here," "We used to have coffee mornings, they were great" and "The staff are about to help me with my favourite hobby, building a model railway."

Relatives told us, "I feel the activities are not always suitable for everyone, my relative needs different stimulation," "The staff are lovely but I don't feel they fully understand the needs of the people here, when it comes to keeping them active" and "Whenever staff arrange an activity it's not very dynamic."

The manager told us they had recently recruited a new activity worker. The person was due to start as soon as final recruitment checks had been completed. There had been no activity worker at the home since prior to the last inspection in November 2015. This meant a full programme of activities was not in place.

We looked at five care plans. We saw information about how people preferred their care and support needs to be met. When people were admitted to the home a pre-admission assessment was completed. This initial assessment was used to decide what areas of care were required to meet people's needs. From this, individual person centred care plans were written for such things as hygiene, mobility, eating and pressure care. Each area of care detailed what staff needed to do to support the person in maintaining good health and well being. Care plans were reviewed each month and some relatives told us they had been asked to contribute to the reviews.
One healthcare professional told us, "I am currently involved with an on-going safeguarding concern in relation to wound care and the documentation around this. At my initial contact with this home following referral, there had been some management changes, and on subsequent follow ups changes had been made to documentation, and some improvement in the wounds. I also asked that the home kept me updated on the progress due to my concerns, this proved a little challenging."

People and their relatives knew how to complain and told us they would inform staff if they were unhappy with their care. People said, "I could talk with my key workers if I had any concerns," "The manager pops in to see me every day to see if I am ok" and "The owner of the home comes to see me. He tells me to let him know if there is anything I need."

Relatives said, "Mum has no problems but I would pop in to see the manager, her door is always open," "I have mentioned a few things to the manager, they are very nice but I have not seen any action yet" and "I will always make sure [name] is safe. I would stop at nothing in complaining."

The provider's complaints policy and procedure was on display in the entrance hall of the home. It provided details of how and who to complain to if anyone had any concerns. The procedure showed how complaints would be dealt with and the timescales that people would be provided with the details and outcome of the investigation. People who used the service and their relatives told us if they had complained their concerns had been taken seriously, investigated and resolved.
We looked at the complaints log and found there were no outstanding complaints about the service.

Inadequate

Is the service well-led?

Our findings

There were mixed reactions from relatives in relation to the management of the home. Some relatives felt very involved and other less so. Most relatives felt unsettled as they said the management structure had "changed drastically" in recent times. Staff also told us they were not settled about the on-going changes taking place in the management of the home.

Relatives told us, "'I don't really know the new manager, she has never made herself known," "I am fed up of the changes in the management. As long as they don't close the home that's my fear," "The management changes are so drastic, when will it all settle down?" "'How can it be 'well run' when there are so many changes," "Apparently there have been meetings with relatives. I wish we could get copies of the minutes then we would know what is happening. I can't always get to meetings," "This home is run well, the residents are really challenging," "We asked for a 'suggestion box' but the manager said "We have an open door policy" so no suggestion box," "We have had a few meetings with the new management, we are hopeful they will act" and "I am really worried staff say there may be changes to the building, that worries me."

Staff told us, "I love working here," "It worries us all about the management changes over the months," "I think we have a great staff team we help each other" and "All these changes in the management make staff morale low."

Although some relatives told us they had been involved in meetings, we were not able to look at the minutes from these meetings as they could not be found by the manager.

The manager had been employed at the home for nine months. They told us they had just started to apply to be registered with CQC. When we asked why this had taken so long the manager said, "I just forgot and nobody at head office reminded me."

There was a lack of effective leadership and management oversight at the service. It was difficult to obtain key pieces of information we would expect the manager to know. For example, they were unable to confirm that all staff had completed a DBS check.

The manager had a system in place to monitor and audit areas of the service. Such as checks on medicines, care plans, accidents and health and safety. Audits are one way a manager can check that standards are being maintained. They also identify any areas requiring improvement. When we looked at the audits we found many were incomplete. For example, at the front of each care plan was an audit sheet which detailed any issues found in the care plan following the managers audit. It listed the action to be completed, person responsible, expected completion and actual date of completion. In the care plans seen the actual date of completion had not been entered. When we checked the actions that were required to be completed we found some were completed and others weren't. We asked the manager if they had checked to confirm the actions required had been completed. The manager said they had not done this as they had expected staff to, "Just do it."

We looked at the manager's audit and analysis of accidents. For September 2016 the analysis showed a person as having two falls from their wheelchair after untying the safety belt. The manager had recorded an action of "Not to be left unattended." In October 2016 the analysis showed the same person had fallen three times after trying to stand up. The analysis stated "Staff advised once again not to leave [name] unattended." We asked the manager if any further action had been taken to reduce or prevent the person from falling. The manager said they were unsure about this but thought the physiotherapist might have become involved with the person's care. This meant there was no follow up process to make sure any shortfalls found from audits were actioned and completed.

Record keeping was inadequate, for example we found discrepancies in the information recorded on food and fluid charts. The manager showed us the audits they had carried out on these charts. After several months of auditing, the charts continued to show errors. In response to this the manager had sent to all care staff (except three) a first written warning letter stating further disciplinary action would be taken if this did not improve. We asked the manager to show us how this had been monitored in order to establish the staff member's responsible for making the errors. The manager was unable to provide any evidence of how they had concluded that all but three of the care workers were responsible for the errors.

From meeting minutes and speaking with relatives and friends it was clear that peoples thoughts and ideas were not always acted upon. The manager told us quality assurance surveys were sent out to relatives of people who used the service throughout the year. We saw 11 surveys had been returned in June 2016. When people were asked what the service did well their comments included, "Provide a caring home," "Provide a safe and clean environment," "Care and nursing staff excellent" and "Management listen." When asked what could be improved most said more staff were needed and there was a lack of social activities and stimulation for people. One person said, "Get rid of the frozen food as it doesn't taste or look good."

We asked the manager if the surveys were analysed and a report written summarising what people had said and confirming the actions to be taken as a result of what people had fedback. The manager told us they had not had time to looked at the surveys. This meant people's opinions of the service were not considered or any actions were taken in response to listening to people.

Staff spoken with said they had attended staff meetings, but said these were not held very often. The manager told us staff meetings were planned monthly. Care workers and nurses held separate meetings. We saw minutes from a care staff meeting held in February 2016 and in March 2016. In May 2016 the minutes stated, "No attendees." There were no minutes from any other care staff meetings. Nurses had held meetings in March, May, July and August 2016. The manager told us there had been other meetings held but the minutes from these had not been "Typed up." We asked to look at these but they could not be found.

Our findings above meant the systems and processes in place for good governance were ineffective in practice.

This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

The registered provider had policies and procedures relating to all aspects of the service provision. These were reviewed and updated each year.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect whilst receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated to ensure people involved with carrying out the regulated activities were of good character and had the skills and competence for the role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced persons working in the home at all times.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way to service users.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes did not operate effectively to assess, monitor and improve the quality and safety of the service and mitigate risks to the health, safety and welfare of people.

The enforcement action we took:

Warning Notice