Mr S Siventhiran

The Oaks Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
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 05, 06 and 24 October 2017 and was unannounced. We found the service required improvement with four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and one breach of the Registration Regulation Health and Social Care Act 2009. You can see what action we told the provider to take at the back of the full version of the report.

At this inspection we found the service was inadequate overall, and in the key questions safe and well-led. The inspection identified five breaches of regulation.
Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 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 Oaks Care Home provides personal care and accommodation for up to 16 older people, some of whom may be living with dementia. There were 16 people who were living at the home on the day of our visit.

There was a registered manager in place at the time of our inspection visit. A registered manager from the providers other service came to support the inspection visit. 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.

Risk's to people were not adequately assessed when people's care needs changed, which meant that staff took actions that put people at potential risk of harm. There were not sufficient staffing levels in place to keep people safe from harm, staff had raised this as an on-going concern, however the registered manager and provider could not demonstrate that staffing levels reflected people's care needs. Staff did not have clear direction for some prescribed medicines, for example, where people who had swallowing difficulties required fluid thickener staff did not know how thick the fluid should be. The storage of controlled drugs and was not locked or secure.

The registered manager did not have checks in place to ensure staff were competent in their roles and in line with best practice. New staff had not received training prior to working and relied on their past experience. Staff supported people with their consent and agreement and staff understood and recognised the importance of this. We found people were supported to eat a healthy balanced diet and with enough fluids to keep them healthy. We found that people had access to healthcare professionals, such as their doctor when they required them.

The home environment did not promote people's independence and dignity. The provider acknowledged in our previous inspection in January 2016 and October 2016 that work was required to improve the bathroom facilities for people, on this inspection we found this had not been completed, with no clear plan in place for when this would happen. People told us that staff treated them kindly and respected their privacy.

People did not always receive care that was responsive to their individual needs as people had to wait for staff to become available to support them. Information on how to raise complaints was provided to people, and people knew how to make a complaint if they needed to. We looked at the providers complaints over the last 12 months and found that one complaint had been received and responded to with a satisfactory outcome.

People and staff did not feel included or listened to in the way the service was run. Staff told us they did not always feel valued. There were ineffective systems in place to ensure the service was delivering good quality care. The provider did not understand their responsibilities in ensuring they were meeting the legal requirements and did not have a robust systems in place to identify areas for improvement. The providers had not been able to assure themselves they were delivering good quality care to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety was not adequately assessed to ensure staff delivered safe care to people. Staffing levels were not adequate to keep people safe from potential harm. Staff recognised signs of abuse and how to report this, however the registered manager did not always report this to the correct authorities. People received their medicines as required however the safe storage of controlled drugs was inadequate.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had the right skills to meet their personal care needs. People received care that they had consented to, and staff understood the importance of this. People had access to healthcare professionals when they required these.

Is the service caring?

Requires Improvement

The service was not always caring.

The home environment did not always promote people's independence and dignity.
People and relatives felt all staff were kind and caring towards them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had to wait for staff to become available before they could be supported with their individual needs. Staff had not always identified people's individual needs and wishes, and because of this people's preferences were not being met. People did not always have the opportunity to take part in interests and hobbies they enjoyed.

Is the service well-led?

Inadequate

The service was not well-led

The provider and registered manager did not lead their staff team to promote a culture that was open, fair and strived to deliver good practice.
The provider continued to not have robust checks in place to identify shortfalls and drive improvement.
Staff did not feel listened to about the running of the service.
Records for people's care and staff records were not always clear, complete or accurate.

The Oaks 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 05, 06 and 24 October 2017 and was unannounced. The inspection team consisted of one inspector 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.

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also spoke with the local authority about information they held about the provider.

We spoke with ten people who used the service and four relatives and two visitors and two visiting healthcare professionals. We spoke with six care staff, one domestic staff and one cook. We also spoke with the deputy manager the registered manager and the provider.

We 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 a sample of people's care records and medication records. We also looked at recruitment, maintenance records and complaints and compliments.

Inadequate

Is the service safe?

Our findings

At our last inspection in October 2016 we rated this domain as good. However at this inspection we have given the provider a rating of requires improvement.

We looked at how people's individual risks had been assessed in a way that protected them from harm whilst promoting their independence. Our findings showed people's risk of harm was not always managed in a consistent way, to ensure they were kept safe from injury or harm. We found three people who lived in the home were not supported by staff and did not use suitable equipment to mobilise safely while transferring from their bed to a chair. One relative told us how their family member was, "Lifted" by the staff and they "Didn't use a hoist". We spoke with staff to understand how they supported the people who required assistance to transfer where people could not weight bare. One staff member told us, "There is nobody that needs to be hoisted". We asked how they supported those people to move safely, they said, "Two carers lift [the person] onto the bed". We spoke with two staff about how they lifted people; both staff explained how they did this by hooking the person under the arms and confirmed that these people could not support their own weight. We looked at each of the person's plan of care to understand what instructions had been given to staff to safely move the person, to help reduce the risk of them coming to harm. The care records for two people did not give staff clear directions to allow them to move the person safely, nor did they reflect the person's most up to date care needs. We found that one care plan directed staff to hoist the person for all transfers; however staff we spoke with told us they had not used the hoist.

We raised our concerns with the registered manager about staff not having the guidance or support to move people safely. The registered manager told us they were unaware that staff were moving people unsafely and would addressed and people's care plans reviewed immediately.

We visited on the 24 October 2017 to understand if people were now being supported to transfer safely following our feedback. We found that staff were supporting one person to transfer safely with the use of the hoist. We found that the other two people had been re-assessed and were identified as requiring a hoist to move them safely. However; there were not enough hoists available for staff to use. The registered manager told us that for one person they were continuously nursed in bed, where there were times they wanted to get out of bed. We spoke with the provider to understand how they were supporting the registered manager and staff to deliver care to people safely. The provider was unable to give us a clear reason why they had not ensured staff had enough equipment for staff to use. Through our conversation with the provider they ordered a hoist immediately.

While no person had suffered any injury as a result of the unsafe practice, people had been placed at unnecessary potential harm. The inconsistent risk assessments and lack of oversight of staff poor practice had put people at potential risk of harm.

We found inconsistencies with staff knowledge on how to use a prescribed thickener, which is given to thicken the fluids given to people who have swallowing difficulties. Three people living in the home had been prescribed thickened fluids; however staff gave us inconsistent answers when we asked how thick each

person's fluid should be. The registered manager was unable to confirm which stage each person should receive. It took the registered manager up to an hour to locate the three prescriptions and identify how thick each person's fluid should be. The prescriptions showed that each person was on the lowest stage, so the risk of harm to people was reduced. However, people were being put a potential risk of harm due to records and staff knowledge not being clear.

Prior to our inspection we received concerns from a staff member about the management of an incident which had involved two people living in the home. We spoke with staff about how they protected people from abuse. Staff were aware of different types of abuse and what action they would take if needed. Staff told us that there had been incidents of one person shouting at other people who lived in the home. Staff told us how they used distraction techniques to help calm and reassure people involved. We spoke with a visiting doctor who told us how staff managed well in supporting people during times of upset and confusion due to their dementia related illness.

We found there had been two recorded incidents of physical abuse between people living in the home, in June 2017 and September 2017. We could see the registered manager had put plans into place to reduce the risk of further harm from occurring from the incident in September 2017. We asked the registered manager if these incidents had been reported to the safeguarding team. The registered manager could not recall reporting the incident in June 2017. We looked at the two people's care records for the incident in June 2017 and the home's reporting system and could not identify that this incident had been reported. We saw that the registered manager had informed safeguarding of the incident in September 2017, but had not reported this to us until we requested this on inspection.
Therefore we could not be assured that people living in the home were always kept safe from abuse. As incidents were not always reported to the correct authorities in a timely way, to ensure adequate steps were put into keep people safe was in place.

People and relatives we spoke with did not raise any concerns about how their medication was managed. One relative said, "I don't know if the hospital has changed [the person's] prescription, I just know that they care for all of their medicines now". We saw in some medication records that where medicines were prescribed for only when the person needed them, the reason had not been recorded. We also found that where one person was sometimes given their medicine covertly, there were no clear instructions on how staff should give this. Staff gave inconsistent answers in how they gave this medicine, for example, one staff member told us they would crush the medicine and put it in the person's cup of tea; however the registered manager said that the medicine should not be crushed. We also found that the storage of controlled drugs was not always safe. When we asked to check the controlled drugs cabinet, we found this was not locked and the door was open. This meant that people and those visiting the home had potential access to controlled substances. Staff and the registered manager explained it was difficult to reach the medicine cabinet, and that the lock for the controlled drugs was difficult to lock. We raised our concerns about the storage of the controlled drug with the provider, who told us they would get a new medicines cabinet, which would be relocated to a place where staff could reach it.

All of the above information demonstrates there was a breach in regulation which was Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Safe care and treatment.

We looked the recruitment files of new staff members who were working in the home. We found that the registered manager had not ensured all new staff had their Discloser and Barring Service (DBS) in place prior to working. Where one DBS for a staff member had shown a potential risk, the registered manager had not adequately assessed whether the staff member was safe to work with vulnerable people living in the home.

While another staff records did not have adequate references in place prior to them working.

Therefore, the provider could not evidence the staff members they had employed had the right skills and were safe to work in the home. The provider confirmed that a professional reference was required, and advised that they would take over the recruitment process from the registered manager.

All of the above evidence demonstrates a breach in Regulation 19 of the Health and Social Care Act 2008 (regulated activities 2014) Fit and proper persons employed.

People and their relatives did not raise any concerns to us about staffing levels. We spoke with staff about staffing levels, who told us they had busy periods of time such as mornings and evenings, but the nights and weekends were the busiest. Staff told us that two care staff supported 16 people during the day, with support from the deputy manager and registered manager during the week. Staff told us that during the night there was one staff member and one sleep-in staff member. One staff member said, "There are not enough staff. After 8pm the management go home and it's hard with two of us to get everyone to bed". They continued to say, "They expect us to do laundry, tidy up, paperwork, medication". And "If I'm the sleep-in staff on nights, I'm always woken up as there are lots of people who need two staff to assist them". While a further staff member said, "It's hard when there are two of us; I'm running around like a headless chicken".

Staff told us that the deputy manager and registered manager assisted them with supporting people during the week days, however, on weekends only two staff members worked during the day. Staff told this made it difficult to meet people's needs and keep people safe. For example, one person who lived upstairs needed support with two staff members which meant there were no care staff downstairs to support people requests for personal care. One person told us they would shout for staff, until someone came. Staff continued to tell us that the senior staff member was then required to do the medication which left one care staff member to support 13 people who only required one staff member to support them with personal care in the morning.

We spoke with the registered manager who was aware of the staffing level concerns raised by the staff, and told us they supported staff where they could by working with staff on different shifts, however this had impacted on their management role. The registered manager told us they felt that was the reason why staff did not always use the hoist to mobilise people was because it was "quicker to lift". From the records that we looked at we could not see how the provider had reflected their staffing levels based on people's needs. We spoke with the provider who had acknowledged that some people's health had deteriorated and they required more support with all aspects of their care, however they could not provide assurance that their current staffing levels reflected the needs of the people living in the home to keep people safe from potential harm.

The registered manager had not reviewed the staffing levels to understand if people were having their day to day care needs met in a responsive way. Staff continued to raise concerns about the pressure to respond to all aspects of people's personal care, however felt this had not improved. The registered manager was unable to demonstrate that staffing levels were determined by people's dependency and could not evidence that the current staffing levels were reflective of people's needs.

The above evidence demonstrates a breach in Regulation 18 of the Health and Social Care Act 2008 (regulated activities 2014) Staffing.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in October 2016 we rated effective as good. However at this inspection we have given the provider a rating of requires improvement.

We received concerns prior to our inspection from a member of staff about the training staff received. At the inspection we spoke with staff about this. New staff we spoke with told us they had not received induction training from the provider before they started work. They also confirmed that their knowledge or past work experience had not been checked to understand if they were competent in their role. We spoke with long standing staff who told us they were not supported to refresh or develop their roles. Staff told us they did not have any formal means of speaking with a staff member in a management role. Staff told us they did not always have the opportunity to refresh their knowledge, for example with medicines training, or improve on their practice, for example with dementia care. Where staff had requested additional training, such as training in diabetes and dementia this had not been sourced for them.

We spoke with the registered manager about how they supported their staff to care for people in line with best practice and how they checked that staff were competent in practice. The registered manager explained that new staff had a probationary period where they updated their training, however the registered manager did not have records to support this, or evidence to show that they had checked staff had understood their training and were competent in their role.

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.

We spent time in the communal areas to understand how staff supported people and respected their wishes. We saw that staff gave people choices and sought their agreement before assisting them. One person told us, "They are flexible with choices". Staff we spoke with understood their roles and responsibilities in regards to gaining consent and what this meant or how it affected the way the person was to be cared for. Staff told us that one person preferred to get up later in the morning, and they respected their choice. Where one person lacked capacity we saw the family had been involved around decision making for the person's care. Where people lacked capacity and their family members were not there to support with decisions around their care we saw the registered manager worked with the other external professional's about their care.

People can only be deprived of their liberty to 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). We checked whether the service was working within the principles of the MCA.

The registered manager was aware who had a DoLS in place. Staff were aware who had a DoLS in place and how this affected their care. We had seen that the registered manager had applied for where people were receiving restrictive care and had worked with the local authority for the correct authorisation for people so they were being restricted lawfully.

Two people we spoke with told us they enjoyed the food at the home. One person said, "The food is good, I had a good breakfast". We saw that staff offered people more snacks and drinks throughout the day. During meal times staff asked people if they were happy with their meal, or if they wanted more. Two relatives we spoke with told they had raised concerns about their family member losing weight. They told us that when they spoke with the registered manager about this, they could see that staff had already addressed this with the person's doctor and had put some plans in place to help maintain their weight. One relative said, "I realise there is nothing to complain about as [the person's name] chooses not to eat much. We are keeping an eye on their weight and trying to give high fat supplements".

Two people we spoke with told us could see their doctor when they wanted. We spoke with a visiting doctor who told us that staff knew people who lived there and their health needs well, and recognised when they became unwell. They felt the registered manager knew people well and listened to what they advised.

Two relatives told us that staff always informed them if their family member had become unwell and needed the doctor or hospital treatment. One relative told us when their family member's health had declined and staff had contacted the doctor. From speaking with staff and looking at care records we could see that other healthcare professionals, such as chiropodists, opticians and dieticians had been involved in people's care.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in October 2016 we rated this domain as good. However at this inspection we have given the provider a rating of requires improvement.

Relatives we spoke with felt the staff were caring towards their family member, but felt the service provision offered to people was not caring. One relative said the person was, "Getting the care they needed, without the frills". Staff we spoke with talked about people with affection but spoke of their frustration of not having the opportunity to offer people the support that was individual them. For example, one staff member told us, "We never have time to take people out. The only time they go out if a relative takes them". They told us that this was because there were not enough staff to be able to offer people the opportunity to go out. Another staff member told us, "We used to do so much with people; there was always something to look forward to. Now people do not do anything".

The facilities within the home environment provided do not actively promote people's independence. At our two previous inspections in January 2016 and October 2016 we found that the facilities for people to wash themselves did not promote their independence. Within the home there are two bathrooms and one shower room. The registered manager had deemed the shower room and the upstairs bathroom unsafe for use, as the access and risk of slipping were high. At the previous inspections the provider told us they had plans to make these rooms suitable for use so people had a choice and to promote their independence. At this inspection we found the provider had not made any changes. Staff shared with us examples of people who had their independence taken away, and told us people were fully reliant on staff for assistance getting into the bath, whereas with a shower some people would require minimal assistance. The registered manager told us how this not only affected some people's independence, but compromised their dignity.

People we spoke felt staff were caring, relatives we spoke with felt staff were caring in their roles. One relative told us, "I've got a great relationship with the carers. They really look after [the person's name]". While another relative said, "The carers are very pleasant". We saw that staff were kind and caring towards people when they spoke with them. One person told us the registered manager was, "Special to me". Relatives told us they were welcomed and encouraged to visit the home. One relative told us, "The owner is remarkable. He gave me his number when we met and said to let him know if we had any problems".

Two visiting healthcare professionals told us they found the staff to be, caring and friendly towards people. They told us that all staff knew people well and were very helpful in answering any questions they may have. They felt that the registered manager and provider knew people well and knew people's history. We spent time in the communal areas of the home and found that staff approach with people was kind and patient. When one person became anxious we saw how staff supported the person, which resulted in the person being more settled and started to smile.

People's right to be treated with dignity and respect was appreciated by the staff we spoke with. We heard staff speaking with people in a calm and quite manner. Where people required assistance to use the bathroom, this was done in a respectful way. All relatives we spoke with felt that their family members were

treated with dignity and respect by the staff. A staff member told us, "We always ask people what clothes they would like to wear, it's important to offer people a choice." Where staff were required to discuss people's needs or requests of personal care, these were not openly discussed with others. Staff spoke respectfully about people when they were talking to us or having discussions with other staff members about any care needs.

Requires Improvement

Is the service responsive?

Our findings

At the inspection in October 2016 we found this area was requires improvement. This was because there were not always enough staff to meet people's needs in a timely way and the lack of stimulation for people who lived in the home. At this inspection we found that people continued to receive care and support that required improvement. This was because we found the same concerns around timeliness of people receiving support and the lack of stimulation for people. The registered manager and provider had not driven any improvement in this area and people continued to poor care.

The registered manager had not always appropriately assessed people's general health and well-being. We found that where people's health had begun to slowly deteriorate and their care and support needs had become greater, the registered manager had not considered all aspects of their care and whether they were still able to meet their care needs. For example, where two people health was declining and they were to be supported with end of life care and were spending more time being nursed in bed, there had not been a clear assessment of the person's most current care needs to ensure staff had the right equipment and aids, such as a nursing bed, to enable staff to raise the head of the bed up, when staff supported the person to eat in bed.

We found that people continued to not be supported to maintain their hobbies and interests. One person said, "There's nothing to keep me busy. I just sit around" and continued to say, "I never go out of the home". A visitor told us, "My instinct is that they [people] don't get a lot of stimulation" and continued to say, "We've not been invited to any social occasions". We saw on the morning of 04 October 2017 that staff interacted with people and spent time talking with them. However we saw other times where either staff sat separate to people.

We did find that where people's health had deteriorated, for example, if their skin had become sore, they were in pain, or they required support with their mental health staff had sought prompt assistance from the person's doctor or alternative health care professionals. Staff, records and two visiting healthcare professionals confirmed that they did follow the advice of external healthcare professionals where necessary.

People, visitors and relatives did not raise any concerns with us about the care but felt they could complain to the registered manager if they needed to. We looked at the provider information they shared with people about how to raise a complaint about the service provision. We also looked at the provider's complaints over the twelve months since our last inspection. We saw that one complaint had been received which had been responded to within the provider's policy with satisfactory outcomes for the complainant.

Inadequate

Is the service well-led?

Our findings

At our inspection in January 2016 we found a breach of regulation 17, Good Governance, in October 2016 the provider had made some improvements around this, with regular support from the local authority and had met the conditions of the breach, but remained as requires improvement in this area. At this inspection we found the provider was now inadequate in this domain.

At our inspection in October 2016 the provider assured us they had understood what they needed to do after the support from the local authority and would put robust quality checks in place to ensure they knew the service was delivering high quality care. At this inspection we found the provider had not put any monitoring tools in place and in failing to do so have not identified shortfalls we saw at this inspection. We found that the service provision had declined in areas such as people's safety, staff training and staff recruitment. Through our conversations with the provider it was clear that they did not understand their legal responsibilities, or have sound knowledge of the regulations that they are legally required to meet.

The provider did not promote an open culture which listened to concerns to understand the cause and address it in the right way. When we discussed with the provider the anonymous whistleblowing concern, the provider did not focus on the concern but only on which staff member had complained. They told us that a particular staff member, "Liked to cause trouble", and dismissed the safety and training concerns as invalid. However, as the provider did not have their own checks to show the service was delivery good quality care they could not demonstrate that this needed further checking.

One staff member told us that the provider only did, "The bare minimum" and they only did what they needed when, "The CQC or the Local Authority tell [the provider] to". The registered manager shared with us their frustration of the provider not listening to them and including them in the way the service was to be run. They felt this was through all aspects of the service, such as changes to the environment, staffing levels, and support to carry out their own management role to enable them to manage staff more effectively. The provider told us that the regularly called the registered manager to check if things were going well in the home. However, they did not carry out their own audits or reviews to understand what was really happening in the home. The provider had no formal systems in place to assure themselves that people were receiving good quality care, delivered by staff that were competent to do so.

Most staff told us they had raised some concerns about aspects of the service, for example, the environment, or staffing levels and felt the provider had not addressed these. Staff told us they felt frustrated that the provider did not listened to them. Staff told us that the last team meeting they had was following CQC last inspection to discuss the findings. One staff member said, "If we mixed up all of our ideas we'd come up with something good for the place. It's like you don't have a voice". Staff told us they did not always feel appreciated and expressed to us there was low morale within the staffing team due to not being listened too.

This had led to staff accepting the provider's culture and had not openly reported where, for example, they had to undertake poor or unsafe care as a result of not having the right equipment to do so or the staffing

levels to respond to people's care needs. This had caused staff to manage the care given to people within the confines of the resources available.

However, we also found that the registered manager did not always lead by example and promote best practice within their staff team. For example we saw them emptying commode bowls without gloves or aprons. The registered manager told us they did not like wearing gloves, but expected the staff to not follow their practice.

We also found that management staff did not always take the opportunity to refresh and improve their skills and knowledge to ensure they led a staff team which followed best practice. We could not be assured that people receive the correct support with their medicines and there was a risk that people received the incorrect care. For example, we found that the registered manager had not ensured staff had clear dosage instructions for administrating the prescribed thickening powder for three people's fluids. We also found some staff who administrated prescribed fluid thickener and prescribed creams, had not received medicines training and had not been had their competency checked.

The provider had failed to put checks in place to ensure all staff were up-to date with their training and that the registered manager was checking staff were competent. We found areas of concern during our inspection, which the provider was unaware of. The provider was unaware that the registered manager's medication training expired in May 2016 and their manual handling training to support staff in their training had also expired.

We found that the recruitment records had not been filed in a way which demonstrated that robust recruitment checks had taken place and the paperwork for new staff was loose piece of paper amongst paperwork for potential new staff.

The lack of monitoring had meant that the provider had not made all of the necessary improvements to the service which had been highlighted by CQC at the last inspection. There were no clear systems in place for the provider to be assured that people living within the home were consistently receiving responsive care that met their individual needs. We also found that people continued to receive lack of stimulation and fill their time with doing things they enjoyed.

Most people living in the home did not comment about the opportunity to discuss the way the service was run. Relatives we spoke with felt they were able to comment about their family member's care, but had not been given the opportunity to feedback about the overall service.

All of the above information demonstrates there was a breach in regulation which was Regulation 17 of the Health and Social Care Act 2008 (Regulated activities)
Regulations 2014. Good governance.

The registered manager did not have robust systems in place for reporting abuse that had taken place in the home. There had been one recorded incident of abuse in June 2017 which had not been reported to the CQC, the registered manager could also not confirm that this had been referred to the local authority safeguarding team. We found that the registered manager had failed to notify CQC about a further incident that occurred in September 2017 that we had been made aware of through an anonymous staff member raising their concerns. Therefore the registered manager had not fore filled their registration responsibilities and notified the CQC where required.

The above information demonstrates there was a breach of Regulation 18 of the Registration Regulation

Health and Social Care Act 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified the CQC of incidents of abuse or potential abuse that had taken place in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's individual risks had not been adequately assessed. People were exposed to potential harm through unsafe practice carried out by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have robust recruitment checks in place to ensure staff were suitable and safe for the role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to keep people safe and meet their needs.

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 provider did not have systems or processes in place to assess, monitor and improve the delivery of the care, the home environment and the staff they employed.

The enforcement action we took:

We served a warning notice under Section 29 of the Health and Social Care Act 2008 in relation to Regulation 17 Good governance, of The Health and Social Care Act 2008 (Regulated Activities).