Tudor Bank Limited

Douglas Bank Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection was unannounced, which meant the provider did not know we were going to visit the home. It was conducted on 22 March 2016.

Douglas Bank is situated on the outskirts of Wigan, in a semi-rural setting. The home enjoys panoramic views of scenic countryside and overlooks the picturesque village of Appley Bridge. The home accommodates up to 40 adults, who need help with personal or nursing care needs, including those who are living with dementia. The majority of bedrooms have en-suite facilities and are of single occupancy, although a few double rooms are available for those wishing to share facilities.

At the time of our inspection the manager of the home had been in post for a very short period of time. She was in the process of applying for registration with the Care Quality Commission. 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 last full scheduled inspection of this service was conducted on 04 August 2014, when some shortfalls were identified in relation to cleanliness and infection control protocols. A follow up inspection was conducted on 04 November 2014, when we found that action had been sufficiently taken to improve the cleanliness of the environment and therefore promote good infection control practices.

At this inspection we identified some areas where improvements needed to be made, which are detailed within each relevant section of the report.

People who lived at Douglas Bank told us they felt safe being there and we found that the recruitment practices were robust, which helped to protect people from harm. There seemed to be sufficient staff on duty on the day of our inspection and it was observed that staff were always present in the communal areas of the home. However, people told us that there were sometimes shortfalls in the staffing levels, particularly at night and records showed there was an excessive number of agency staff used over a short period of time.

The staff team had received training in safeguarding adults and whistle-blowing procedures. However, people's Personal Emergency Evacuations Plans (PEEPs) were out of date and therefore did not provide current guidance. We made a recommendation about this.

The management of medicines was poor and there were areas of the environment and external grounds, where improvements to safety were needed.

Some areas of the home could have been cleaner and more hygienic. Infection control practices could have

been better.

Care plans did not always reflect people's assessed needs and some care records provided conflicting information. This did not give the staff team clear guidance about how people's individual needs were to be best met.

Social care profiles were in place in each person's care file, which reflected people's preferences and what they liked to do and needs assessments had been conducted before people moved into the home.

Deprivation of Liberty Safeguard (DoLS) applications had not always been submitted, in line with the requirements of the Mental Capacity Act. Records showed that people's mental capacity had not always been considered when developing their plans of care and formal consent had not always been obtained from the relevant people before care and support was provided.

We observed that confidential records were sometimes left unattended on the nurses' station, although there was always a member of staff in the vicinity. We have made a recommendation about this.

The provision of meals could have been better, although we saw people being supported with their meals in a sensitive manner. We have made a recommendation about this.

The majority of staff we spoke with had a good understanding of people in their care and were able to discuss their needs well. The staff team were well supported by the management of the home, through the provision of information, induction programmes and training. However, supervision and appraisal could have been more structured. We have made a recommendation about this.

Interaction by staff with those who lived at the home varied in quality. Some members of staff provided good, sensitive and caring approaches, whilst others failed to promote people's dignity and respect.

Records showed that people's views about the quality of service provided were sought in the form of surveys and meetings. However, complaints were not always being managed well.

The provider had forwarded the required notifications to CQC, as and when required. The system for assessing and monitoring the quality and safety of the service provided was not always effective. This did not allow for shortfalls to be identified and improvements to be made.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for person centred care, dignity and respect, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance, need for consent, premises and equipment, receiving and acting on complaints and fit and proper persons employed.

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

Inadequate

This service was not safe.

During the course of our inspection we found some areas of the internal and external environments, which created a potential risk for those who lived at the home and environmental risk assessments were out of date.

The home was found to be malodourous and visibly unclean in some areas, which did not promote good infection control practices. The management of medications was poor.

Records showed that staff had received training in safeguarding policies and whistle-blowing procedures. Staff members we spoke with confirmed this to be accurate and they told us that they would report any concerns they had about the safety of someone who lived at the home, without delay.

The Personal Emergency Evacuation Plans [PEEPs] were out of date and therefore some did not provide accurate information. We made a recommendation about this.

Recruitment practices adopted by the home were robust. However, we established that an excessive amount of agency staff were being used, which did not always benefit those who lived at the home.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Staff members we spoke with were fully aware of the assessed needs of those in their care. New staff members were guided through an induction programme when they started to work at the home. The staff team received a range of mandatory training modules, as well as training relevant to people's needs. However, we did have some serious concerns about the competence of one member of staff around the management of medicines. Plans were in place to introduce a more structured approach to regular supervisions and annual appraisals for all the staff team.

Parts of the premises were in need of upgrading and

modernising, particularly the toilets, showers and bathing facilities.

The provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty and formal consent had not always been obtained from the relevant person.

People's nutritional requirements were being met, but the management of meal times was not well organised, particularly on the dementia care unit. We made a recommendation about this.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The care plans we saw incorporated the importance of privacy and dignity, particularly during the provision of personal care. However, our observations varied in relation to people's needs being respected. We saw some positive interactions and caring approaches towards people who lived at the home. Some choices were offered and individual wishes were often respected, but we also witnessed several inappropriate responses made by some staff who were working at the home.

We saw that, although at least one staff member was always present in the lounge area on the ground floor, confidential care records were often left unattended on the nurses' station, which was located in the lounge. We made a recommendation about this.

Is the service responsive?

Requires Improvement

This service was not always responsive.

Although assessments of people's needs had been conducted before people moved into the home and the plans of care had been reviewed and were person centred in parts, we found that they did not consistently cover all assessed needs and sometimes conflicting information was provided. Some areas could have been more explanatory and guidance provided more appropriate, in places.

Complaints were not being well managed and on the day of our inspection, the provision of activities could have been better.

Staff interaction varied in quality within different parts of the home. However, those we spoke with had a good understanding

of people's needs and they were confident in providing the support people needed.

Is the service well-led?

Requires Improvement

This service was not consistently well-led.

Everyone we spoke with provided us with positive feedback in relation to the new manager of the home. However, there were a significant number of areas which were unsatisfactory and in need of improvement. These had not been recognised by the provider and therefore a number of breaches of the regulations were identified.

Feedback from those who lived at the home, their relatives and staff members was actively sought through surveys and meetings. This allowed the manager to establish how satisfied people were with the quality of service provided.

A range of policies and procedures were available for the staff team, which provided guidance in relation to current legislation and good practice guidelines.

Douglas Bank Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 22 March 2016 by four Adult Social Care inspectors from the Care Quality Commission (CQC).

At the time of our inspection of this location there were 36 people who lived at Douglas Bank. We were able to speak with ten of them and five family members. We also spoke with thirteen members of staff and the manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we 'pathway tracked' the care of six people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records, quality monitoring systems and the personnel records of four staff members.

The provider returned the completed Provider Information Return (PIR), within the requested timeframes. 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.

During the inspection we conducted a SOFI (Short Observational Focussed Inspection) on the dementia care unit over lunch time. A SOFI helps us to observe the level of staff interaction provided for a small group of people over short pre-set time frames.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents, injuries and deaths. We were in regular discussion with local commissioners and community professionals about the service provided at Douglas Bank. We asked six community professionals for their feedback and we received one response.

Inadequate

Is the service safe?

Our findings

Comments from people we spoke with varied. We were told that spot checks were conducted during the night. One person we spoke with, who lived at the home said, "If we need anything I just ask and a carer always helps me. I don't need to wait at all." Another commented, "I feel safe here and if I had a problem I would talk to one of the staff." And a third told us, "I get on with everybody. I feel safe."

However, one person said they felt staff were verbally abusive. We observed staff shouting, "Where are you going?"; "What are you doing?" and "Sit down!" The tone of voice used was inappropriate. One person said, "Whatever you do someone's watching you and shouting at you. To me that is being picked on." Another told us, "There is a nurse on at night, who does not give me my pills when I ask. The nurse says, 'I can't hear you' and just ignores me." These comments were brought to the attention of the manager who advised us that she would explore them further.

A person contacted us by telephone and provided us with some feedback about the service provided. She told us that she is concerned that the home uses a lot of none permanent staff. She feels that this is less person centred and that there is a lot less accountability, as they don't know the residents. The residents seem stressed and uncomfortable with them due to some communication difficulties. She reported that she has seen and heard staff shouting at residents, telling them to sit down and also failing to respond to resident's calls for help when they call to need personal care.

Comments from family members included, "I am really happy with the care he gets from the day he came. All the staff are really nice"; "I know mum's in safe hands here. I have no worries at all and I am very happy she is here"; "She feels safe here. We are starting to relax"; "They [the residents] are safe here. It is a home from home" and "I can go home at night and sleep."

We observed two care workers lifting one person from a wheelchair to a lounge chair in an inappropriate way. This unsafe manoeuvre made the person involved shout out. We informed the manager about this at the time of our inspection. This persons' plan of care was later provided, which stated, '(Name removed) requires a handling belt to aid her transfer and the support of two staff. (Name removed) can be very noisy and shouts when being supported with her transfers.' We have been made aware that one family raised concerns with the previous manager about poor moving and handling practices earlier in the year.

We witnessed several altercations, both verbal and on two occasions physical between people who lived on the dementia care unit, resulting in staff intervention. We felt that this was possibly due to a lack of personal space for people within the communal areas. However, it was pleasing to note that the new manager was introducing necessary changes to minimise physical or verbal altercations. The lounge and dining area on this unit had just undergone changes to improve communal space and we were told that meal time seating areas were being trialled at the time of our inspection. However, due to lack of space people also had to walk past the hot food trolley at lunch time, which was potentially a risk for people who used the service. We did not see any environmental risk assessments in place in relation to this.

We found the provider had not always ensured that safe care and treatment was provided for service users, by assessing the risks to their health and safety, doing all that was reasonably practicable to mitigate such risks and ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. This was in breach of regulation 12(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our visit we toured the premises and external grounds. We noted that some environmental changes had been made internally since our last inspection, such as new floor covering in parts, decoration and a nurses' station had been installed. However, we observed a number of easily identifiable hazards. These included: The absence of a restrictor on the first floor bathroom window, a broken window restrictor was evident on another window on the first floor and two areas where there were plug sockets, which were highly loaded with extensions and a number of plugs. We saw a gate used to protect people from using a narrow, spiral staircase, which was unsafe for their use, was frequently left open throughout the day. We also noted the presence of potentially harmful items such as toiletries, drink thickener and cable pins in various areas that were accessible to people who used the service. We looked at the toilet and bathroom areas and found them to be in need of repair.

The external environment to the front of the premises was in-keeping with the rural surroundings and the characteristics of the home. A cobbled court yard was surrounded by the building on three sides. The provider tells us that this area is not used by those who live at the home, due to safety aspects of the cobble stones. The drive ways leading to the property had been resurfaced since our last inspection and external lighting had been improved. However, the external environment to the rear of the home was not safe for people to access. Uneven surfaces made walking difficult and hazardous. The fence had fallen over and was in urgent need of repair. A raised manhole cover in the grounds presented a trip hazard and a large pile of rock salt bags were also a potential risk. This did not provide a safe external environment for people who used the service. The windows at the front of the home had been replaced the previous year, which took many months to complete and the provider told us that a rolling programme was in place to replace all windows, including those in a poor state of repair to the rear of the property.

We looked at how safety of the premises was being managed. We were provided with documentation showing that environmental risk assessments had been conducted each month. These outlined who was at risk, measures implemented to control risk and additional strategies to be introduced in order to further reduce the element of risk. However, these were not effective, as areas in need of improving in order to promote people's safety and well-being had not been identified.

Records showed that systems and most equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to ensure they were safe for use. The testing of portable appliances was two months overdue and needed to be addressed.

We found that the provider had not always ensured that the premises were safe to use for their intended purpose or that equipment used for providing care or treatment was safe for such use. This was in breach of regulation 12(1)(2)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted some areas of the home to be malodourous, which did not promote good infection control practices and which did not provide a pleasant environment throughout for those who lived at Douglas Bank. Some parts of the premises were seen to be visibly unclean, particularly on the first floor, where we found toilets and bathrooms to be dirty and in need of complete refurbishment. Toilet floors and carpets were not clean and we did not observe any hand sanitizer in the toilet areas.

We found that the provider had not always ensured that risks associated with infection control had been appropriately assessed, in order to prevent, detect and control the spread of infections. This was in breach of regulation 12 (1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, the communal areas and bedrooms on the ground floor were clean and fresh. Staff and families on this unit felt it was clean. Toilet areas did have hand cleanser available. Pedal bins and paper towels were provided. We observed staff using personal protective equipment whilst serving food and rigorous hand washing regimes were carried out to prevent cross infection. The recent food hygiene inspection conducted by the Environmental Health Officer earlier in the year resulted in a level 5, which corresponds with 'very good', the highest level achievable.

During our inspection we assessed the management of medicines, which we found to be poor. On several occasions we saw the medicine trolley left unlocked and unattended, sometimes with medicines on top of the trolley, including loose tablets in a dispensing cup. On one of these occasions an inspector waited by the trolley for several minutes for a staff member to return, as they were concerned about people's safety.

The lunch time medication round was still on-going at 3pm. We checked the Medication Administration Records (MARs) and found that the staff member administering these medicines had not noted on the MARs that they had been given later than prescribed, which would have been good practice. We asked the staff member why she was still giving out medicines at 3pm. We were told that she was waiting for the registered nurse to supervise her. However, we had observed this staff member doing a medicine round unsupervised earlier that day, when she was seen to leave the medicine trolley unlocked and unattended with potted medicines on top of the trolley. Also one of the medicine trollies was not tethered to the wall.

On further investigation we found this staff member was not a registered nurse, but a Supervised Practice Nurse (SPN). She was qualified, as a nurse in her home country, but had yet to complete her adaptation course in the United Kingdom. We discussed this with the manager of the home, who told us that this member of staff had not yet passed their International English Language Test (IELTS). This was of concern, as we saw her administering medicines in an unsafe way on two occasions.

We found that one person had missed a morning medication, which was prescribed weekly. We spoke with the SPN, who was administering the medicines that day and pointed the omission out. She did not seem to understand the instructions when we talked it through and would not have realised the medication had been missed had we not brought it to her attention.

There were a number of people prescribed a thickener for their drinks to assist them to swallow safely. Only one person had specific quantities written on their MAR chart; all others we saw stated, 'as directed.' We checked two of the tubs of thickener and found the labels also stated, 'as directed' and there were no specific instructions in the care plans. Therefore, there was no guidance available for staff to indicate the correct amounts to be given.

Some errors were noted on the MAR charts. There were several medicines, which had not been administered that morning or at lunchtime. We gave a list of these to the nurse, as there were quite a number. There was also one medicine which had been signed for as being given on the following day, which was obviously an error and could have been confusing for staff. There was no balance carried over for medications, so they were not auditable.

We had observed one person on the morning of our inspection in an upset and weepy state. We overheard this individual telling carers she was in an awful lot of pain. At one point we heard her say, "I can't think

about anything, but this dreadful pain." She was crying for much of the time. We heard a care worker ask her if she had been given pain killers. She said she had, but went on to say, "They don't seem to be touching it anymore." The carer responded by saying, "Don't worry the doctor is coming to see you today and hopefully he will prescribe something a bit stronger for you."

When we looked at this person's MAR chart we found that she was prescribed paracetamol four times a day, which she was consistently receiving. However, she was also prescribed codeine for breakthrough pain up to eight tablets a day. The last dose she had received of her codeine was at teatime two days previously. We spoke with the SPN again. We asked why this person had not been given her codeine that morning. The SPN told us she had not needed it. We advised that we had observed the resident to be experiencing pain. The SPN responded by saying, "When I was doing the round she was laughing and happy." We spoke with the resident, who was confused, and although able to tell us that she had got terrible pain, she wasn't able to recall if she had been offered her analgesic [pain killers] that morning.

We spoke with the carer, who we had seen reassuring this individual during the morning. We asked, "In your opinion did [name removed] need her pain killers this morning?" The carer replied, "She always needs them. She gets a lot of pain." We asked the manager to make a referral under safeguarding procedures, as the home had been neglectful in supporting this person with pain control.

We established that the MAR chart for another person failed to include one prescribed medication, which was to be given 'as and when required' and there was no information in the care plan highlighting when this medicine should be administered. We could not find this medication in the trolley. The nurse told us she had administered the last one in the box that morning, but that there was some more upstairs. We asked her to get the box from upstairs. She returned advising us that these tablets had run out of stock. We felt this would not have been discovered until the resident had needed another dose of the medication.

Some MAR charts were without photographs for identification purposes and some handwritten entries on the MAR charts had not been witnessed or countersigned, in order to reduce the risk of transcription errors. There were no charts available for those prescribed local applications, such as creams and ointments, to identify which areas of the body these should be applied to.

We also viewed the MAR chart of one person, which showed he had no known allergies, but when 'pathway' tracking his care and treatment earlier, we noted a hospital discharge summary showed that he had an allergy to aspirin and statins. We pointed this out to the nurse for immediate attention. These failings in medicines management did not protect people from harm. The monthly auditing system adopted by the home was less than effective, as many shortfalls had not been identified and actions to rectify areas in need of improvement had not been documented. The most recent medication audit had been conducted the day prior to our inspection and this had been awarded a score of 89.6% with a rating of 'Good.' Our findings at the time of our inspection did not match the results of the medicine audit conducted the previous day.

We found that the provider had not ensured systems were in place for the proper and safe management of medicines. This was in breach of regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that there appeared to be adequate numbers of staff on duty on the day of our inspection and we saw staff members were always present within the communal areas of the home. However, call bells were not always answered in a timely manner. One member of staff told us, "We do use agency staff a lot. Not good really."

We looked at the staff rotas and saw that the use of agency staff was excessive. We calculated that 35 night shifts were covered by agency care staff within a two week period. Most of these agency care workers were employed by the same care agency and were allocated three or more night shifts, with some working a number of consecutive night duties, which did help to maintain continuity of care for those who lived at the home. Three night shifts were covered by agency nurses during the same period of time. Records showed that there were no night shifts during this time, when permanent members of staff were not on duty.

People who lived at the home told us they were not entirely happy with current staffing levels at night. They said call bells were generally responded to quickly during the day, but they felt less safe at night and had experienced slow responses to requests for medicines. One person commented, "During the day staffing is ok but they struggle at night." And a family member said, "There was a one week delay in getting her on to an increased dose of medicine because it hadn't been picked up."

We received a written response from a group medical practice, which told us that the dementia care unit looked well run. However, an increase in home visits had been noted in recent weeks. The GPs felt there was a clear shortage of qualified nursing staff. On one occasion a GP was unable to leave medication instructions, as there was no qualified staff available to talk to. Another GP said instructions were not carried out, which led to a medication error and impacted on a person's health.

The GPs felt that there were quite high stress levels and disorganisation around medication dispensing times and communication breakdowns. The GPs put all of this down to the shortage of staff, as they felt that the staff who work at Douglas Bank were clearly caring and hard working.

We had serious concerns about the competence of an SPN. We brought this to the attention of the manager. We asked the manager about the competence assessment and monitoring framework for senior carers and nursing assistants. She seemed very unclear about this area of supervision. She thought the two senior nursing assistants employed at Douglas Bank were still undergoing their English and maths tests. We asked the manager about the mentoring framework, which she didn't seem to know anything about. We asked her if the SPN, who we saw administering medicines in an unsafe way, had a competence assessment for this particular area of practice, but she did not know. We asked the manager about competence assessments for new staff. We found an example of a new nurse being recently appointed. The manager told us that this member of staff had completed her induction at a sister home, but that she had not seen it. Therefore, she had not properly satisfied herself of the competence of the new employee.

We found the provider had not always ensured that persons employed had the qualifications, competence, skills and experience which was necessary for the work to be performed by them. This was in breach of regulation 18 (1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members we spoke with told us they had undergone training in relation to safeguarding adults and records we saw confirmed this information to be accurate. They were also fully aware of the whistleblowing policies and were confident in reporting any concerns in the most appropriate way. One member of staff told us, "All staff get safeguarding training when they first start. I know about whistleblowing and would use it." Another commented, "I would report any concern to the manager straight away and I feel she would investigate it."

Risk assessments were seen, which covered areas, such as pressure care, bed rail safety, moving and handling, nutrition and falling. These contained guidance for staff about maintaining the safety of people's health and social care, but many had not been reviewed for some time. Therefore, information provided was not always accurate and current. This was discussed with the manager at the time of our inspection, who

confirmed that she would bring these risk assessments up to date.

Fire prevention policies were in place and individual Personal Emergency Evacuation Plans (PEEPS) had been implemented for each person who used the service. These were retained in a separate folder in a central location for easy access. However, some of these were very much out of date and did not always reflect the support people needed. For example, one person's needs assessment stated she had a hearing loss and staff should talk to her from the front. Her PEEP stated she had no hearing loss and also did not provide guidance about how her anxious and sometimes aggressive behaviour needed to be managed in the event of evacuation. Another contained written advice stating, 'Could be difficult', but no other information was available about how to support the person, should they need to be removed from the premises quickly. Therefore, sufficient information was not always provided for the emergency services to assist people to vacate the premises in the most appropriate way, should evacuation be needed. We recommend that the PEEPs be updated with current information and accurate guidance.

Accidents and incidents were documented appropriately and these records were retained in line with data protection guidelines. Weekly audits were conducted of accidents and incidents, which enabled the manager to identify any recurring patterns or themes and which provided a good audit trail in this area.

During the course of our inspection we looked at the personnel records of three people who had worked at Douglas Bank for varying periods of time. We found that recruitment practices for these people were robust, which helped to keep those who lived at the home safe. Each staff member's file contained two written references and Disclosure and Barring Service (DBS) checks. DBS checks highlight if the prospective employee has received any criminal convictions or cautions. This helps the provider to decide if the individual is deemed fit to work with the vulnerable people, who live at the home. Each applicant had submitted recognised forms of identification. They had also completed health questionnaires and application forms. We saw that the provider had sought valid documents from the home office for overseas employees, to demonstrate they were eligible to work in this country.

Requires Improvement

Is the service effective?

Our findings

Comments from people who lived at the home varied. These included, "You can talk to any of the carers whenever you want to. They all listen." And "I keep telling them I want to go home, but they don't listen, so I am not happy with that."

We asked one person what he was having for lunch. He said, "I don't know." We asked, "Don't they [the staff] tell you what it is?" He replied, "No. You just have to have what they give you." We asked what would happen if he didn't like what was given to him. He answered, "It's always tasty. They [the staff] might give you something else, I'm not sure."

A family member we spoke with told us, "I have to travel to get here, but I have had quite a few phone calls just to let me know everything is fine, which helps." And "I am totally impressed here. The staff are very knowledgeable."

During the course of our inspection we looked in detail at the care and support of six people who lived at Douglas Bank Nursing Home.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The plan of care for one person stated they lacked capacity, but did not describe in which areas. There was a mental capacity assessment in place, but this was generic and did not include decision specific assessments. However, there was a record of a best interest decision around the provision of personal care, to which the individual was frequently resistant. This stated that the issue had been discussed with the person's son and an agreement had been reached to 'make' the individual have a bath twice a week. We were very concerned about this decision and the terminology used within the best interest decision record. There was no indication that any other professionals had been involved in the decision and no views of the person or the family recorded. In the best interest decision record, under the heading, 'Record views of others', a care worker had written, 'Due to data protection these can be found in the care plans throughout the home.' This did not make sense, so we asked a carer if they knew what it meant and they did not. We did see another best interest decision meeting had been held, in relation to a DoLS application, which had involved the individual concerned and their relative.

We noted several restrictive practices being used during our inspection, such as the use of bed rails and key

codes. We saw some plans of care, which showed people lacked capacity and that Deprivation of Liberty Safeguards (DoLS) authorisations had been applied for, but some of these had been submitted some time ago and no outcome or indication they had been followed up was evident.

An application for Deprivation of Liberty Safeguards (DoLS) authorisation was seen in two people's care files and all forms and assessments were completed in line with legal requirements. However, there was no underpinning mental capacity assessment in place for one of these people, in order to determine their level of capacity, before the DoLS application was made.

We observed one particular person repeatedly asking to go home, but a DoLS application had not been submitted. We advised the manager that an urgent application should be applied for without delay, at the same time as applying for a standard authorisation. The manager of the home should ensure that mental capacity assessments are conducted for all those who may lack capacity, are not free to leave the premises and are under constant control. This will help to determine if DoLS applications are required. The Care Quality Commission (CQC) is now responsible for monitoring the use of DoLS and should now be notified of any authorisations immediately.

Staff members we spoke with did not have a good grasp of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). It would be beneficial if the provider considered some additional training for the staff team in these important areas.

We found that the provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty. This was in breach of regulation 13(1)(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans we saw had not always been agreed by the person who lived at the home, or their relative. Therefore, it was not evident that people had been given the opportunity to be involved in planning their own care or that of their loved one.

We saw some consent forms to be present within the care files we looked at, but the range of areas of consent could be extended to always incorporate the taking of photographs, sharing of information, administering of medication, care and treatment and the use of bed rails. A good percentage of those we saw had been signed by family members. However, we were told by the manager of the home that no Lasting Power of Attorney (LPA) authorisations were in place for those who used the service. Consent can only be given by a person who has been authorised as having LPA, or a deputy from the Court of Protection (CoP).

We found that the provider had not always ensured that consent had been obtained from the relevant person before care and treatment was provided. This was in breach of regulation 11 (1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that staff were using the conservatory on the ground floor as a staff room and people who used the service were not accessing it. This was of concern as the conservatory was a communal area, which should have been available to people who lived at the home. We also noted that the conservatory was in an untidy state with undrawn curtains, various spare heaters and used crockery. Family members we spoke with were unhappy that the conservatory was in use as a staff area, because previously it had been a pleasant area where families could visit their relatives in private.

Some areas of the environment had been refurbished since our last inspection and we saw records of work

that had been completed. The provider told us that there is a rolling programme of maintenance. However, we found that the premises, in general was in need of upgrading and modernising, particularly the bathrooms, showers and toilets.

The care home was not particularly 'dementia friendly'. We did see one red door and a red toilet seat, but these had been in place for a while. Other doors and toilets were not of contrasting colours, which would have made them more easily identifiable for those who were living with dementia. Further appropriate signage on bathroom and toilet doors for those people with cognitive difficulties or confusion would have proved beneficial and would have reflected a more person centred approach to providing care. It is recommended that the provider consults the NICE and Alzheimer Society guidelines related to dementia care environments.

Although Douglas Bank had a total of 20 en-suite bathing facilities, we were concerned that at the time of our inspection there was only one working assisted bathing area for everyone who lived at the home. A high percentage of people who lived at Douglas Bank had complex nursing needs and required assisted bathing facilities for personal care. We were told that the assisted wet room was under repair following a leak and that two shower rooms were available.

We found that the provider had not ensured that the premises throughout was being properly used and was properly maintained. This was in breach of regulation 15 (1)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two of the inspectors assessed the management of meals on both units and sampled the food served at lunch time. The menus we saw were on a four weekly rotational basis and offered two choices of each course. Breakfast consisted of a wide range of foods, such as cereals, fruit juices, toast and a full English breakfast for those who wanted it. However, on the day of our inspection we saw that a daily menu was displayed on the wall of the dementia care unit on the first floor, but this did not relate to the lunch time meal served, which could have been confusing for those who lived on this unit. On the ground floor the correct menu was displayed in the dining area, but this was written in small print, which was difficult to read. We were told that staff asked people's preferences for lunch and dinner during the day. Staff told us this meant that people had the opportunity to choose alternatives, when they saw others being served.

The lunch we saw was a choice of soup and a range of sandwiches which were fresh, tasty and attractively served. Hot and cold beverages were also available throughout the day. A cold drinks machine was also available, so people could help themselves to cold drinks, or ask a staff member to get one for them.

Dining tables on the ground floor were pleasantly set with place mats, artificial flowers, cutlery and condiments. The food served on both units was nutritious, well balanced and well presented. People were able to eat their meals within the privacy of their own accommodation, if they preferred to do so.

We sat in the dining room on the dementia care unit, where twelve people dined over two sittings. Staff members were present at all times in the area and wore protective clothing, whilst serving food. Four people required help to eat their lunch, supported by two members of staff. One of these care workers told us, "We do use picture menus to help people make a choice and that helps them to decide what they want to eat."

The atmosphere in the dining room on the dementia care unit was fairly noisy and two people got somewhat agitated with each other. There was no pleasant background music playing. One person was continually walking up and down the unit. Another individual required some personal care during the lunch time period and was supported by a member of staff in a safe and appropriate manner. We observed staff

members to be patient with people, interacting well with them during lunchtime. The dining experience on the ground floor was calmer and more organised. We recommend that the provider assesses the management of meals, in order to promote a pleasant dining experience on both units.

We noted that dietary and food intake was monitored where weight loss had been identified as a risk and people were weighed regularly, so that any significant weight loss could be quickly addressed. People were given supplements and fortified diets, in accordance with their nutritional requirements.

We saw that a Speech and Language Therapist (SALT) had assessed some people's swallowing reflexes. Soft diets and thickened fluids were in use on their recommendation. However, the two thickeners in use were used generically. They were on the drinks trolley and used without reference to dosage or to which person they had been prescribed.

We saw carers helping people who required assistance and had swallowing problems to eat. They were well aware of the person's needs and how best to stimulate a safe swallowing reflex and followed the SALT recommendations. They encouraged the person to eat with good humour and kindness. One person who lived at the home told us, "I can't grumble about the food. If there is something you don't like they fix you up." And another commented, "The food is lovely. We get plenty of choice."

There was evidence in the care plans we saw that community professionals were involved in people's health and social care needs and specialised equipment, such as pressure mattresses and profile beds had been supplied, in accordance with people's needs. People's plans of care contained their medical history, likes and dislikes. One person told us, "They call a doctor if I need one. I go to hospital appointments by ambulance or taxi, accompanied by a carer." We spoke with a community professional who visited the home whilst we were there. She provided us with positive feedback about the care and support of those who lived at Douglas Bank.

We established that new employees were provided with induction programmes and were issued with a range of information when they first started to work at the home, such as job descriptions and terms and conditions of employment. These informed them of what was expected whilst working at the home and outlined their duties specific to their individual roles.

The permanent staff members we spoke with had a good understanding of their roles towards those who lived at Douglas Bank. Care workers were able to explain in detail the needs of several people who lived at the home.

Individual training records and certificates of achievement were present in staff members' personnel records. These covered areas, such as moving and handling, dementia awareness, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff members we spoke with told us they received supervision. One care worker said, "We do get supervisions. I have had a couple over the last few months." However, we did not see any records of supervisions, which had been conducted this year. We discussed this with the manager of the home, who agreed that this was an area which needed to be reinstated. The comments made by one member of staff during their supervision five months previously were quite negative. However, we were able to speak with this individual who told us that she was a lot happier now and conditions at the home had greatly improved with the arrival of the new manager. The annual appraisals for staff were also sporadic and plans were in place for these and regular supervision to be more structured. This would help staff to improve their work performance and focus on their personal development.

Requires Improvement

Is the service caring?

Our findings

Comments from those who lived at the home included, "I make my own mind up about what time I go to bed. I just tell a carer and they will help me"; "When they get time they will spend time with us and have a talk, but they do get busy. " And "It is nice here, lovely."

Comments we received from family members included, "I don't think you could find more kind and caring staff anywhere"; "The environment is not great, but the staff are wonderful. It's a lovely, lovely home"; "Everyone is really helpful. It has a lovely feel"; "Visiting hours are restricted and we have to leave at 11.45am, come back at 1.30pm and leave again at 3.45pm. That doesn't work well if you have travelled a distance and want to visit for the day"; "We are very happy with the way they are caring for her." And "She is doing fine. They are looking after her. It's a home from home. It's my home too. I can come here anytime I want."

We saw a lot of thank you cards from relatives, which included messages, such as, 'With many thanks for the love and care given to mum over the years and especially during her final days with you. Your kindness to us as a family is very much appreciated' and 'We would like to express our sincere gratitude for all the care and attention you have given to [name removed] over the past years.'

We saw that those who lived at Douglas Bank looked well-presented and smart in appearance. Some of our observations were very positive. We saw care workers knocking on people's bedroom doors before entering and supporting people in a warm and caring manner, whilst enjoying a chat with those who lived at Douglas Bank. However, we did note some interactions were not quite as positive. For example, one person, who appeared disorientated and unsettled, was walking about saying she was looking for the toilet. A care worker was walking past and did not stop to help. The carer just told the individual, 'It's over there' and pointed in the general direction of the toilet. It would have been good practice for the carer to stop and accompany the person, to ensure they located the toilet. We later saw the same care worker walking with another person to the toilet. This individual obviously wanted to chat, but the carer was responding in a cold manner, with very brief answers. For example, the person asked, "Where are we going?" The Carer replied, "To the toilet." The resident asked, "Is it time for bed?" The carer replied, "No, you are going to the toilet."

We heard throughout the day, particularly on the ground floor unit, staff constantly telling people to 'sit down.' We observed one person frequently standing up and shouting out, and the staff constantly told her to sit down. The person sitting next to her showed more concern for her wellbeing than the staff did. He was also told to sit down regularly by staff. One member of staff told us, "[Name removed] does get upset quite easily, but we always sit with her and try and explain things."

We observed staff were very busy, but most frequently paused to speak with people and to check whether they required support. However, one agency staff member was supporting one person on a 1:1 basis. He sat in the lounge next to the person he was supporting not speaking, but occasionally told to another person across the room to sit down.

We found that the provider had not always ensured that people were treated with dignity and respect. This

was in breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they were offered a variety of choices, such as where they would like to sit, what they wanted to do, what they wanted to wear, whether they wanted to be supported or not and what time they wished to get up.

We did see occasions when staff were respecting people's wishes. A nice family gathering was taking place, where several family members had visited to celebrate their loved one's birthday. They sat in a quiet area of the lounge and were left to enjoy their celebrations in peace. We saw staff provide glasses and plates for the wine and cake they had brought.

On the ground floor care files were kept in the nurses' station in the middle of the lounge. The cabinets were lockable, but we did see care plans unattended on some occasions throughout the day and not locked away. However, there was always at least one member of staff present in the lounge area. We recommend that the provider assesses the appropriate storage of confidential records.

We also saw that this nurses' station was where the home's telephone was situated. We were concerned about confidentiality and the possibility of people overhearing private calls. The manager told us that staff were able to take the telephone into a private area, if they needed to.

The care records we examined incorporated the need for privacy, dignity and independence, particularly during the provision of personal care. They also included people's end of life wishes, which involved their relatives, as appropriate.

Requires Improvement

Is the service responsive?

Our findings

One person we spoke with said, "I can't remember doing any surveys or having a meeting, but I know the manager and I can talk to her." Another told us, "I talk with the carers every day and would speak with one of them if I had any concerns."

Comments from family members included, "Yes. I have completed a few surveys in the past. The last one was not so long ago"; "Not a problem. I would be happy talking to one of the carers or the manager if I had a complaint"; "The staff don't automatically do things. We keep an eye on everything." And "The staff are good. If you ask for anything they sort it out straight away."

During the course of our inspection we 'pathway' tracked the care of six people who lived at Douglas Bank Nursing Home.

The plans of care we saw varied in quality. In some we found many areas had not been reviewed for several months. We noted that one person who was assessed as being anxious and agitated had no management plan in place for this area of need and had not been referred to the mental health team.

We viewed the care plan of another person, who was fed through a Percutaneous Endoscopic Gastrostomy (PEG). This is a tube entering the stomach, directly through the abdominal wall. There was no information in their plan of care about the specific feeding regime or care of the tube and site of entry.

Some information in the care plans we saw was confusing. For example, one stated, 'No history of mental health problems - has a history of depression.' This provided conflicting information in one sentence and there was no guidance for staff about how the person could be supported with their depressive illness.

We found some care planning was inappropriate. For example, one person's plan of care stated 'Can sometimes be aggressive and says he wants to die.' The intervention for this was, 'Tell him this is not acceptable.' There was no guidance for staff about how to support this individual or how to reassure him in relation to his morbid thoughts.

In other examples we saw that information in care plans could have been expanded upon. For example, the plan of care for one person described sexually inappropriate and aggressive behaviours. The interventions were not well detailed and included instructions such as, 'Use distraction techniques.' However, it was not clear what distraction techniques might be helpful for this particular individual.

We saw one person shouting, "Help me, help me." This individual seemed very distressed for a good part of the day. However, there was no care plan in place around this state of anxiety and therefore staff had not been provided with clear guidance about how to manage this individual's behaviour.

We found the registered person had not always ensured that the plans of care had been designed to reflect individual needs. This was in breach of regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

We noted that a system was in place for the recording of complaints received by the home. One member of staff told us, "To be honest we don't get many complaints. I can't remember the last one we had." We looked at the complaints log and found that one complaint; made earlier in the year, had not been managed well. This resulted in family members not being informed of a fall, which their loved one had experienced and paramedics were not alerted to relevant medical details. It was established that the family member could not be contacted because the new contact details, given to a member of staff had not been recorded in the care file. The outcome of the internal investigation was recorded and this stated that relevant medical information was sent to the hospital with the injured person. However, it was also written that it was explained to the relative that, 'It is a common occurrence for this documentation to go missing on arrival at the A & E department.' We found this quite concerning. Therefore, it is recommended that the manager of the home pursues any missing records with the hospital and ambulance service. One person told us, "I complained about the member of staff on nights not giving me my pills when I asked for them. I was listened to. It improved at the time, but has gone back again. I could speak to the manager if I needed to."

We found the provider had not ensured that an effective system had been implemented for identifying, receiving, recording, handling and responding to complaints. This was in breach of regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that pre-admission assessments had been conducted before people moved into the home. These covered areas of daily living, such as eating and drinking, falls, personal hygiene, sexuality, socialisation, medication, skin integrity, communication and end of life wishes. This helped the staff team to be confident they could provide the care and support required, before a placement at Douglas Bank was arranged.

Some care plans had been reviewed regularly and were person centred in parts. For example, one plan of care stated, 'Do not rush or outpace [name removed]', another told us, '[Name removed] requires reassurance from staff.' A 'My Life - My Choices' record clearly documented people's history, leisure interests and preferences. This helped the staff team to build a picture of those who lived at the home. However, a one page personal profile would be helpful for staff, so they could see at a glance the support people needed.

We did see some good examples of person centred information within the plans of care, such as, 'likes to watch rugby on TV' and 'loves to listen to music and use his lap top.' Staff interactions varied in different parts of the home. We saw in one area the staff to be kind, caring and attentive. They were laughing and joking with those in their care, which people seemed to enjoy. In another area staff were not interacting with people and on some occasions were ignoring them.

Most staff we spoke with showed a very good understanding of those who lived at the home and their assessed needs. They were fully aware of the issues and potential problems that might occur. They seemed confident in the support they were providing.

On the day of our inspection we did not observe any activities taking place. We were told that the activity co-ordinator was off duty. However, we saw a weekly activities programme in the reception area of the home, which included beauty treatments, music, crafts, walking, memory boxes and crosswords. On the day of our inspection there was little stimulation. The unit ground floor unit had music playing in the background and a television programme to watch at the far end of the lounge. One person told us that she enjoyed watching specific programmes available to her in the home. Family members we spoke with felt there were sufficient

activities provided on the ground floor, but they wished people could go out in small groups more often. One person who lived at the home said, "There's not a lot to do. You sit about and get a book. I don't join in the quizzes" and another told us, "You can do what you like. I watch the TV and DVD in my room. We had rabbits visiting us yesterday, birds last week. I enjoyed that." It is recommended that the provider assesses the provision of activities within the home and supports people to pursue their individual leisure interests.

Requires Improvement

Is the service well-led?

Our findings

The new manager of the home had recently been appointed and was in the process of applying for registration with the Care Quality Commission (CQC). She was off duty on the day of our visit, but she attended the home in order to assist the inspectors during their visit. Family and staff members we spoke with were very positive about the current manager, describing her as supportive and approachable. One senior care worker felt that the new manager had made some very positive changes at the home, since her appointment.

Everyone we chatted with spoke positively about the new manager of the home. Comments we received included, "I think the manager is nice here. I think all the staff are nice too"; "I think I know who the manager is. I don't think she has introduced herself yet, but I would be happy to talk to her"; "The manager was fantastic in responding to our concerns"; "I have recommended this home to others"; "[Name removed - the manager] came over to speak to me as soon as I came in today. She always does [visitor]"; "The manager has made some great changes since she came in. She just needs some time I think. She does keep in touch"; "There have been some big changes here since [name removed – the manager] took over. I am really happy here now"; "I know the manager and feel I could talk to her if I needed to"; "It has really improved since she [the manager] arrived" and "The manager is very approachable. Her door is always open." We observed a prominent notice which stated, 'Open door policy.'

A community professional told us, "It has picked up over the last couple of years. In the main things are done well. There is more organisation now. Management is much better this year."

The manager's monthly auditing system covered areas, such as medication, care reviews, pressure ulcers, complaints, health and safety and meetings. The result of each audit was presented in a percentage. It was clear that the assessment and monitoring systems in operation at the home were not consistently effective, as they had failed to identify areas in need of improvement, which we noted during our inspection.

We found the registered person had not established and operated effective systems to assess, monitor and improve the quality and safety of the services provided or to mitigate risks relating to the health, safety and welfare of those who lived at the home and others who used the premises. This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that surveys for those who lived at the home and their relatives were conducted during the year prior to our inspection. These were also available in picture format. This allowed everyone the same opportunities to provide their feedback. Some of the surveys were 'focused' questionnaires. For example, we saw one asking people about the quality of food served. Others covered a range of areas, such as care, complaints, attitude of staff, involvement and cleanliness of the environment. This helped the management team to seek people's views about various aspects of life at Douglas Bank. Most responses we saw were, in general positive. One care worker told us, "We have done surveys and we have meetings for families as often as we can."

Records showed that residents and relatives meetings were held regularly. This allowed people the opportunity to discuss various topics in an open forum, should they wish to do so. We saw the minutes of several of these meetings. One person had said in one of the meetings, 'The staff here are wonderful. Nothing is too much trouble for them.'

The manager of the home told us that regular meetings were also held for the staff team, so that any important information could be disseminated throughout the workforce. This enabled those who worked at the home to discuss any relevant topics and to keep up to date with any specific changes.

The regional manager compiled very detailed reports following her regular visits to the home and the provider had forwarded the required notifications to CQC, as and when required. Copies of these were also retained on site for easy reference. Any serious incidents or accidents had been reported to the relevant authorities. We saw there were a wide range of written policies and procedures within the home such as, health and safety, whistleblowing, safeguarding adults, infection control, advocacy and discipline and grievance. This helped the provider to ensure the staff team were kept up to date with current legislation and good practice guidelines.

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 did not take formal enforcement action at this stage. 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 9 HSCA RA Regulations 2014 Person-centred care We found the registered person had not always ensured that the plans of care had been designed to reflect individual needs.

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 We found that the provider had not always ensured that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent We found that the provider had not always ensured that consent had been obtained from the relevant person before care and treatment was provided.

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 The premises were not safe throughout and equipment used for providing care or treatment was not always safe for such use. Risks associated with infection control had not always been appropriately assessed, in order to

prevent, detect and control the spread of infections.

We found that the provider had not ensured systems were in place for the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found that the provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment We found that the provider had not ensured that the premises throughout was being properly used and was properly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We found the provider had not ensured that an effective system had been implemented for identifying, receiving, recording, handling and responding to complaints.

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 We found the registered person had not established and operated effective systems to assess, monitor and improve the quality and safety of the services provided or to mitigate risks relating to the health, safety and welfare of those who lived at the home and others who used the premises.

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 We found the provider had not always ensured that persons employed had the qualifications, competence, skills and experience which was necessary for the work to be performed by them.