Akari Care Limited

Philips Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We conducted the inspection from 10 July 2018 to 23 July 2018. It was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting.

In September 2017, the local authority commissioners raised concerns around the operation of the service. The provider agreed to not accept new placements and this was regularly reviewed by the local authority and on 12 July 2018 this ended.

We completed a comprehensive inspection on 14 September 2017 and found the provider was meeting the fundamental standards of relevant regulations. We rated Philip's Court as 'Requires improvement' overall and in all five domains. We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment, maintaining people's privacy and dignity, providing personalised care and having good governance systems in place.

Following the inspection, we asked the provider to complete an action plan to show what they would do and by when to improve.

On 30 January 2018 we completed a focused inspection to check that improvements were being made. We found that although some improvements had been made and they were now compliant with the regulation related to maintaining people's privacy and dignity. The provider however, continued to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action plan they had previously sent stated they expected to be compliant with the regulations by the end of June 2018.

Philips Court is a care home which provides nursing and residential care for up to 75 people. Care is primarily provided for older people, some of whom are living with dementia. At the time of our inspection there were 63 people using the service.

The service had a registered manager in place. 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.

At this inspection we found that action had been taken to resolve the issues found at the last inspection.

We found practices had improved but the staffing levels on the downstairs nursing unit often prevent these from being fully implemented.

On the downstairs nursing unit staff were expected to complete 15-minute observation for six people on this unit, as they were prone to falling. We observed practices on the unit and found for long periods of time staff were not visible. The 15-minute checks were not completed but the records were retrospectively filled in to

suggest this had happened.

We found there were insufficient staff to ensure effective observations were completed and the quality assurance processes had not identified this issue.

Four door sensors were in place across the service. We found only one was working and this had a warning light on suggesting the battery was running out. Staff believed all were working and were unable to tell us who was responsible for fitting sensors or how these were checked.

We found that staff were being supported to complete training but the provider needed to ensure there were sufficient qualified first aiders to cover 24 hours every day. Staff had not completed falls prevention training or being taught how to use bed, floor and door sensors.

During our visits we found that the temperatures in the service exceeded 25˚c. The registered manager informed us that the provider had authorised them to have air conditioning units fitted.

We observed the meal time experience and found on the first day that the meal-time was chaotic and it took two hours for everyone to have a meal. Also, staff adopted poor practices when handling food such as leaving food with people who needed support for over 20 minutes then putting it back in the food serving trolley to warm until staff were free to assist.

Staff knew the people they were supporting but the care records still did not always reflect this. Staff needed to ensure that care plans did not act as an assessment and detailed the interventions. When other professionals suggested monitoring the impact of interventions staff needed to make sure there was a process in place to do this.

Staff understood the principles of the Mental Capacity Act 2005. We discussed how decisions made for people in their 'best interests' and how assessments could be enhanced to cover practices, which were imposed and restrictive for people who didn't have capacity to make decisions.

Since the last inspection it was noted that improvements had been made in relation to the overall cleanliness of the service. Additional cleaners had been employed. However, staff needed to ensure the food serving and cutlery trolleys were clean.

We found that the registered manager kept information about complaints that had been made but there were no records about the investigations or resolution. We also found no records to show they investigated incidents or what lessons were learnt. However, the deputy manager could readily discuss what action had been taken and accepted better records needed to be maintained.

We found that improvements had been made to the management of medicines. However, staff needed to ensure all appropriate action was taken when medicine was given and different administration methods.

We found that the registered manager completed a range of audits but these did not pick up issues we found. Although they analysed incidents and accidents this was not completed fully so did not explore issues such as the number of unwitnessed falls for people who were regularly checked.

We found that the provider's quality assurance system did not proactively support people to complete a critical and thorough review of practices.
The service had experienced problems with ants but we found action had been taken to deal with this

matter.

Staff were familiar with the safeguarding protocols in place to help keep people safe.

We noted that improvements were being made to the environment. An additional maintenance person had been employed.

Plans were in place to re-create a dementia-friendly environment following the recent refurbishment.

People spoke positively about the staff at the service and their attitude. We found that staff were kind and caring.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to staffing; and having good governance systems in place.

This is the second consecutive time the service has been rated Requires Improvement.

You can see what action we told the registered provider to take at the back of the full version of the report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels on the downstairs nursing unit needed to be improved.

There needed to be sufficient qualified first aiders.

Action was needed to ensure when 15-minute observations were in place staff completed the checks and maintained accurate records.

Staff were recognising signs of potential abuse and reported any concerns.

Risk assessment were in place. Action taken to involve others in determining how risks could be managed.

Recruitment procedures were completed in line with best practice.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff needed to ensure 'best interests' assessments were completed when staff imposed restrictions on people.

Staff were in the process of receiving all the training and supervision they needed. However, staff needed to be given access to training around falls prevention and how to use risk management technology such as sensors.

The service did not have air conditioning, which led to the service being excessively hot. Staff needed to give more drinks out.

People were supported to access health professionals when needed.

Is the service caring?

Requires Improvement

The service is not always caring.

Staff spoke with people in a kind and caring manner, but we saw that they did not always offer people a choice.

We found that on the downstairs unit staff needed to improve how they engaged with people and monitored the support being offered.

Relatives told us they felt people generally received good care but improvements needed to be made to ensure people consistently received good care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records did not always reflect people's needs.

We could not establish if complaints that had been made had been thoroughly investigated, as investigation reports were not available.

There was no written evidence to show that action was taken to review incidents and determine how lessons could be learnt.

Activities were available for people to take part in. People told us they were able to come and go as they liked.

There were opportunities for people to give their views about the home.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits in place were not effective and didn't find or address issues we found during our inspection.

The provider had not ensured the systems for assessing and monitoring the performance of the service were effective and assisted staff to critically review their practices.

The registered manager was taking action to improve the operation of the service but further work was needed.

There was a registered manager at the service.

Philips Court

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 registered 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 unannounced inspection was undertaken from 10 to 23 July 2018. The inspection team consisted of an adult social care inspector and an assistant inspector.

Before the inspection, we spoke with local authorities' commissioning teams and reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also reviewed reports from recent local authority contract monitoring visits and attended multidisciplinary meetings held about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 10 people who used the service and six relatives. We also carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We also spoke with the registered manager, deputy manager, three nurses, a senior carer, seven care staff, the cook, two members domestic staff team and the activities coordinator.

We observed the meal time experience and how staff engaged with people during activities. We looked at seven people's care records, as well as records relating to the management of the service. We looked around the service and went into some people's bedrooms, the bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

The service was rated Requires Improvement at the last inspection and this rating has not changed.

When we inspected on 30 January 2018 we found that the management of medicines needed to be improved. The internal courtyard presented several trip hazards and the lighting was poor. A designated fire exit was being blocked. The care records varied in quality.

We wrote to the provider asking them to outline how they would make the necessary improvements. The provider sent us action plans detailing what they would do and by when.

At this inspection we found these matters had been resolved.

We noted that from when the day staff arrived people were offered regular drinks. However, during our visit there was a heatwave. Throughout the visits the temperatures in the building exceeded 25˚c. The registered manager told us the provider was installing air condition but this was not in place. They told us that staff had on previous days offered extra drinks and ice-pops but this had not occurred when we were there. No instructions were given to staff about managing the increased risk of dehydration or checks to make sure ample fluids were available.

We saw that were fluid monitoring charts indicated people had drank less than 1000mls of fluid but there was no information to suggest any action had been taken. Also, some staff had put in sheets that they used to calculate how much fluid people should have but staff had not used these properly so the figures were wrong. We discussed this with staff who believed this was a recording error and the people in question always drank plenty of fluids.

We also found that four door sensors were in place on bedroom doors but only one worked. This sensor was showing the battery was low. Staff thought they were working and if the alarm was activated this would connect to the nurse call, which was incorrect. We discussed this with the registered manager and deputy manager who immediately asked the maintenance person to make sure these sensors were working and to regularly check them.

We found that some people had repeatedly experienced unwitnessed falls, although bed sensors, door sensors and 15-minute checks were in place. The accident monitoring sheets recorded when falls occurred but had not triggered any review of why people had an unwitnessed fall when so many measures were in place to reduce this risk. We discussed with the registered manager the need to identify reasons why people under such close observation experienced unwitnessed falls. This analysis would enable consideration to be given to providing additional staff support and resources.

We found the standard of cleanliness and hygiene of the premises had been improved. The domestic staff numbers had increased from two a day to three. Domestic staff members said, "This had made a big difference, as we can really keep on top of things and do a deep clean more often."

However, on the residential unit we saw the trolley that dishes and glasses were transported to and from the kitchen was dirty and stained. The food trolley was also dirty. Tea cups and cutlery was stained. There was not enough crockery for all people which meant staff had to wash dishes in the dining room sink. Due to the water temperature being restricted in this area it is not appropriate to wash up as it creates a risk of infection.

We asked staff who was responsible for cleaning the dining area about this and they advised us that deep cleans were carried out by night staff. These deep cleans did not appear to be happening as would have picked up the issues. The cleaning audits had not identified this shortfall.

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

At the last inspection we found information about people's needs had been used to determine the number of care staff needed to support people safely. However, the consultant psychiatrist we spoke with told us that the people they visited they had extremely high dependency needs but this was not reflected on the dependency tool.

We saw that on the residential unit, although two staff were deployed, for long periods of time there was only one member of staff available to assist people. This had the potential to put the other people in the lounge at risk of unsafe care.

At this inspection we found the registered manager had reviewed the dependency tool and ensured it now provided staff with the opportunity to accurately reflect people's needs. We found that an additional staff member worked on the residential unit.

We found although improvements had been made to the dependency tool issues remained, as there were insufficient staff on the downstairs nursing unit. The way staff were deployed meant no one was covering the main communal area and there was a noticeable absence of staff presence.

We saw that over lunch two dining rooms on the downstairs nursing unit were used. Seven people needed assistance to eat in one dining room and three people in the other. Staff also needed to take meals to people who chose not to go to the dining room. We found that the deployment of staff in this manner led to people waiting for over an hour for a meal.

Six people on this unit were on 15-minute observations but we found there were insufficient staff to complete these checks. We sat in the lounge with one person who had this level of observation for over a hour, throughout this time no checks were completed but staff recorded that they had been.

We found that the number of staff on the downstairs nursing unit was insufficient to meet people's needs and led to people not receiving the level of support they needed.

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

People had mixed views about the service. People who used the service told us they felt safe. Relatives discussed the improvements to the service and how they were confident that people's needs were met. But other relatives were extremely dissatisfied with service, for example how their relative was supported when unwell, the management of falls and medicine.

One person said, "I find they do a good job." Another person on the residential unit told us, "The staff are always there if I need them." Another person said, "I am happy here."

Relatives commented, I am happy with the care my husband receives here, he seems happy." Another relative told us, "They haven't got a clue. They need to do more to make the place safe."

We found that risk assessments were detailed and addressed issues. Staff had identified when people, for instance, were at risk of falls. Staff contacted appropriate professionals such as fall prevention teams, speech and language specialists and dieticians when risks were identified around people having falls, being at risk of sustaining pressure ulcers or losing weight. Staff also obtained equipment such as bed sensors and air flow mattresses.

We discussed with staff hygiene, the infection control process and the availability of personal protective equipment (PPE). Training had been completed in infection control.

Staff understood what actions they would need to take if they had any safeguarding concerns.

We found Personal Emergency Evacuation Plans (PEEPs) were available for the people who lived at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions. Staff had checked that the qualified nurses remained registered with Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

The service was rated Requires Improvement at the last comprehensive inspection in September 2017 and this rating has not changed.

At the inspection in September 2017 we found that some people become anxious at times and display behaviours that may challenge the service. Each person had been prescribed 'as and when required' medicines to be administered when they became distressed. There was no clear guidance within the records to advise when staff needed to administer this medication. Also, there was no step by step guidance to inform staff about how to support people in alternative ways.

We found staff were not always ensuring people received meals and drinks. Guidance and advice provided by healthcare professionals was not always acted upon.
At this inspection we found these issues were resolved.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations.

Staff had received training in the Mental Capacity Act 2005 and DoLS authorisation. Staff appropriately recognised when people had or did not have the capacity to make decisions. However, they were not completing the 'best interests' decision forms when restrictions were imposed such as giving medication covertly, preventing people from leaving the building or using bed rails. We discussed this with the registered manager who told us there was some confusion in the organisation about when to use them, as different guidance was given by different organisations. We reminded the registered manager that the guidance is set out on the Department of Health's website and in the MCA code of practice and this needed to be followed.

The provider's care record template did not prompt staff to establish who had enacted lasting power of attorney for care, welfare and finance and if the Court of Protection had appointed anyone to act as an individual's deputy.

Staff had been trained to meet people's care and support needs in topics such as working with people who lived with dementia. Records showed staff had received training in subjects that the provider deemed to be

mandatory, such as moving and handling, health and safety, safeguarding and first aid that needed to be updated. However, we found that staff had not be trained to use the door sensors and other fall prevention tools. Also, staff were not trained in falls prevention. Seven staff were qualified first aiders but the registered manager had not checked that this was sufficient to provide a first aider 24 hour a day.

Following the last inspection, the registered manager had introduced new tool to assess people's needs. This had limited space and led staff to use care plans inappropriately as an assessment. The use of care plans in this manner meant the staff did not record in detail how to meet a person's needs. The registered manager agreed to improve the assessment tool.

The registered manager showed us the provider's latest assessment tool. This was a tick box assessment form, which did not allow staff to describe how the person was impacted by their condition. We found this would not be effective.

On the first day we found on the downstairs nursing unit that the service of the meal time was chaotic, there were only two staff in each dining room. We saw that people were encouraged to sit down for a meal 45 minutes before it was served, many people got up and left. This led to staff spending time trying to get those people back into the dining room or to take a meal to them.

We observed staff get one person's meal but this was left on the table for 20 minutes as they needed support to eat and no staff were available to assist them. Once staff member noticed the person was still waiting for assistance the meal was put back in the food trolley for another 15 minutes. This practice is not in line with how to manage the risk of bacteria developing.

We drew this to the attention of the manager who during their audits had noted some difficulties with the management of meals so extended the times for lunch. However, they had not noted that the lay out of the building and staff deployment was impacting how staff delivered the meals.

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

Staff had been supported with regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff.

We saw that a full refurbishment programme had been completed but work was still to do to ensure the physical environment throughout the home reflected best practice in dementia care.

One person said, "The staff are smashing and do know how to help me." Another person said, "Staff are good at the job."

We found staff ensured people were appropriately referred to other healthcare professionals. For example, we saw staff had referred people to the falls team. We saw advice had been sought from other health care professionals when needed, such as a dieticians and mental health professionals.

Requires Improvement

Is the service caring?

Our findings

The service was rated Requires Improvement at the last comprehensive inspection in September 2017 and this rating has not changed.

At the last inspection we found that the culture within the service compromised people's dignity and staff did not understand people's diverse needs. We found since then the registered manager had taken action to ensure staff met people's needs and were respectful.

We spent time observing care practices although staff were respectful when interacting with people who used the service there were insufficient staff on the downstairs nursing unit to make sure they could always respond to peoples' requests for support. We saw that for over an hour no staff entered the lounges. People did not have access or the ability to use the nurse call alarms in these lounges. This meant staff could not be aware if people needed support

On one occasion a person asked for a 'nice piece of cake' when a staff member entered the lounge. The staff member got them some cake and left the room. Minutes later another staff member came in and told the person they needed to come with them. The person said they did not want to leave the room but was encouraged to do so. When they returned to the lounge they had lost interest in eating the cake. We found it would have been more appropriate to leave this person to eat the cake as they were struggling to maintain a healthy weight.

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

Recent refurbishment work had been completed and action was yet to be taken to ensure the environment was dementia-friendly. The registered manager acknowledged this and confirmed that within the refurbishment programme work was being completed to create an environment that would be suitable for people living with dementia.

The majority of people we spoke with felt they were well cared for and staff treated them with respect. One person said, "I think they are all marvellous." Another person said, "I like the staff, they are nice." Another person said, "The staff do care about us."

Relatives told us they thought the staff were very kind but those visiting downstairs found staff did not have time to spend time with people. One relative said, "They all seem nice enough." Another person told us, "We find the staff always try their best to make people feel happy." Another relative commented, "Staff just don't have the time and we can never find anyone when we visit."

We saw that information about advocacy services was available to people and when needed the staff enabled people to access these services. Advocates help to ensure that people's views and preferences are heard where they are unable to articulate and express their own views.

Requires Improvement

Is the service responsive?

Our findings

The service was rated Requires Improvement at the last comprehensive inspection and this rating has not changed.

At the September 2017 inspection we found that the care records did not fully address people's needs. Action needed to be taken to ensure the current records were organised so immediate risks such as choking and falls were not lost amongst the paperwork.

At this inspection we found that the registered manager had introduced the care templates they had designed. Staff had now completed these in detail and ensured people's needs were outlined. The difference in quality of these we noted at the January 2018 inspection. However, we still found some differences in quality as care records contained different sets of the provider's records. For instance, in several people's records we found guidance on the volume of fluids needed but this was not in other individual's care records.

We also found at times the information in the care records was inaccurate. For example, one person had documents stating they received medicines covertly, this is when a person requires their medicines to be disguised in food or drinks to enable them to take them safely. Not all the required guidance for this type of medicine was present. There was no care plan detailing how staff were to give the medicine. We also found there was no supporting records from other healthcare professionals to give permission to give medicines in this way. We discussed with the registered manager who told us the person was not receiving medicines covertly.

In another person's file we saw information to suggest that staff actively prevented them from leaving the building unaccompanied and persuaded them to utilise the internal garden. Again, there was no care plan or 'best interests' decision in place. Thus, we could not establish what actions staff were to take to dissuade the person from going out. We discussed this with the registered manager who told us that this person did not attempt to leave the building.

We queried how the registered manager could be assured that records were accurate when were some were not. They told us that regular audits were completed and these would pick up issues. However, the recently completed audits had not identified these problems.

Charts were used to document people's food and hydration intake and positional changes but staff were completing these all at the same time. We observed staff at 11am filling in the observation charts and what was recorded did not reflect what had happened.

We spoke with a visiting relative who told us they felt able to complain to the staff if they had any concerns. However, we found that were complaints had been made none of the investigations and only one response to the complainant was kept on file. There was no information to show staff had acted upon or reported these concerns to the manager. We discussed this with the registered manager and the deputy manager

they confirmed the matters had been investigated and accepted that these documents should be readily available.

We found that when accidents occurred such as people experiencing repeated falls no incident analysis was completed to determine why. Therefore no one picked up that staff were unable to complete regular observations, sensors were not working and care records were inaccurate. This lack of robust review meant that lessons had not been learnt. One family had raised in April 2018 that door sensors were not working yet this had not prompted the registered manager to ensure the sensors were regularly checked. This lack of lessons learnt meant that when we inspected the staff did not know how the door sensors worked, no regular checks were in place and the door sensors were broken.

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

On the first floor nursing unit four people received one-to-one support from staff. Throughout the visit we saw therapeutic activities were taking place with these people. Staff encouraged individuals to engage in activities, which would be interesting or stimulating for them. During their interventions with people receiving one-to-one support we saw that they would chat to other people and encourage group activities such as discussions about people's favourite activities.

People and relatives told us that the activities coordinators were good at their job and every time they visited there was a range of interesting events happening. The activities on the whole occurred in a very large communal lounge at the centre of the service. People said, "I come here every day and there is always something happening." Another person stated, "I really like the activities but sometimes think we could go out more often." A relative said, "They seem to enjoy the activities."

We found people were engaged in meaningful occupation and the activities coordinator had tailored the programme of activity to stimulate each person and entertain individuals. The activities coordinator was enthusiastic and we saw they organised group events, which people from across the service could access. The service also had a courtyard garden that was occupied in the centre by chickens and rabbits.

However, if people did not join these activities we found there was no items such as newspapers, jigsaws, doll therapy or other such items people could use on the units. The registered manager told us that within the programme of making units dementia-friendly people would be given access to items that would provide meaningful occupation.

At the time of our inspection people were receiving end of life care, when this was appropriate. Staff understood the actions they needed to take to ensure pain relief medicines were available. Care records contained evidence of discussions with people about end of life care so that they could be supported to stay at the service if they wished.

Requires Improvement

Is the service well-led?

Our findings

The service was rated Requires Improvement at the last inspection and this rating has not changed.

At the inspection in September 2017 and in January 2018 we found multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. We found that the provider had not identified these shortfalls and addressed them.

At this inspection we found that, although the registered manager had been reviewing the service and making changes these had not always identified issues. We again found the quality assurance procedures were not effective. For instance, the tool the provider had supplied for monitoring accidents and incident did not assist staff to look at wider issues, so staff were not looking for patterns or trends. This lack of critical review meant the registered manager had not seen that staff were not able to complete the 15-minute checks and were filling forms in retrospectively.

The quality monitoring systems had not picked up variations in the contents of the care records and that some records contained inaccurate information. We found staff needed to ensure appropriate measures were in place when covert medicines were given. Although the registered manager had amended the dependency tool it didn't accurately reflect what staffing levels were needed or when people required 15-minute observations.

The audits failed to note the lack of training around falls prevention or that there were insufficient qualified first aiders to cover the 24-hour period.

We found staff time was not organised effectively to meet people's needs, for example, the meal-time experience needed improving, the audits had not noted that splitting units into two made it more difficult for staff to support people have a meal in a timely fashion.

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

Since the last inspection a deputy manager had come into post who had been a nurse tutor and clinical lead in a hospital. We found that they had been supporting the registered manager to improve the service. They discussed the critical review that had been completed but acknowledged the lack of written evidence, analysis of lesson learnt was unhelpful.

The manager took up their post at the end of August 2017 and in April 2018 they became the registered manager. Staff reported that the registered manager was supporting them to improve the service. They held regular meetings with the staff. The people and relatives we spoke with, were positive about the service and felt it was improving.

Services that provide health and social care to people are required to inform the CQC of deaths and other

important events that happen in the service in the form of a 'notification'. The registered manager had submitted the required notifications. This meant we could check that appropriate action had been taken.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established systems or processes, which operated effectively to ensure compliance with the legal requirements. Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of skilled and experienced staff be deployed at the service. Regulation 18 (1) and (2)