Mr Anthony John Bloom

Devonia House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Devonia House is a nursing home for older people registered to accommodate a maximum of 32 people. People using this service may have a diagnosis of, or conditions relating to, dementia.

At the last inspection in April 2015 we found the provider had breached nine regulations associated with the Health and Social Care Act 2008. We found people's care plans did not contain person specific mental capacity assessments, applications for the Deprivation of Liberty Safeguards had not been carried out appropriately. Care plans were not updated on a regular basis, some sections were not completed or were inaccurate. There were not enough staff to provide support to people who used the service; recruitment practices were not safe. The provider had not taken steps to ensure staff received ongoing or periodic training, supervision and an appraisal to make sure competence was maintained. The management of

Summary of findings

medicines did not protect people from the risk of unsafe care or treatment. Risks were not fully assessed for the health and safety of people who used the service. The provider had failed to monitor the quality of the service to identify issues.

As a result of the inspection in April 2015 the overall rating for this provider was 'Inadequate'. This meant that it has been placed into 'Special measures' by the Care Quality Commission (CQC). As a result of concerns identified at the inspection placements to the service were suspended by Devon County Council and the local Clinical Commissioning Group (CCG).

We told the provider they needed to take action. The provider sent us an action plan, however the action plan was not adequate and did not provide specific, measurable and time-based outcomes. With support from the local authority 'quality assurance and improvement team' the acting manager developed a second action plan with specific timescales included. We were concerned that the timescales given showed the service would not be fully compliant until 31 November 2015. The acting manager explained as they did not have sufficient time to 'manage' the service they felt the timescales were realistic. We met with the provider and acting manager in early in November 2015 to discuss the progress of the action plan. It was clear that little progress had been made with the action plan to ensure the service was meeting regulations.

The provider's action plan stated they would be compliant with the safe management of medicines by 17 August 2015. On 11 November 2015 two CQC medicines inspectors completed an unannounced focused inspection to look at medicines handling in response to concerns found at our previous inspection in April 2015. At the inspection the medicines inspectors found people's medicines were not managed safely and the planned improvements had not been fully implemented.

Since the last inspection the service has received considerable support from the local authority 'quality assurance and improvement team' and from health and social care commissioners. Regular monitoring visits had been undertaken by health and social care professionals.

Since the last inspection the service had experienced problems ensuring nursing shifts had been covered. In December 2015 the provider had been unable to recruit and retain nursing staff and they had been unable to obtain agency staff to cover deficits over the Christmas period. Subsequently the provider made the decision to stop providing nursing care at the service. This came into effect from January 2016. Two people were transferred to alternative services as Devonia House could no longer meet their needs.

At the time of this inspection the home did not have a registered manager. The service has not had a registered manager since December 2013. However, with the assistance of the local authority, a new manager had been recruited and appointed. The manager started working at the service on 25 January 2016 and on the last day of the inspection they had been in post for five days. 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.

Staff had failed to recognise a potential safeguarding issue and a referral had not been made to the appropriate agencies, such as the local authority safeguarding teams, when this was needed. Not all staff were aware of the process for reporting safeguarding concerns.

The registered provider had not carried out an analysis of need and risk as the basis for deciding sufficient staffing levels. As a result staffing levels were inconsistent. There were shortfalls in recruitment procedures, which potentially put people at risk from receiving care from people not suitable to undertake a caring role. Staff were not trained or supported to ensure they understood their role and responsibilities and could meet people's needs effectively.

The service was not complying with the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). At least one person was being deprived of their liberty and right to consent unlawfully.

People's care plans did not always contain sufficient and relevant information. People's health needs were not always monitored or managed effectively and they were at risk of not having their health needs met. People's nutritional needs were not always identified and monitored. Nutritional care plans lacked detail or clear

Summary of findings

instructions for staff about how to support people in relation to eating and drinking. Records relating to people's daily dietary intake were poor. This meant we could not tell in any detail what people had to eat each day and whether they were receiving sufficient nutrition.

People's care needs were not effectively communicated to staff. Staff had not seen people's care plans and relied on a verbal handover for information. As a result people did not always receive care in accordance with their care plans.

Although people using the service reported an improvement in staff's approach and attitude, describing them as 'kind, caring and friendly', practices within the service were institutional and were not person centred or person led. This meant that people were not always given meaningful choices in relation to their daily routines. People's dignity was not always promoted.

People were not consistently supported to live full and interesting lives. They had little opportunity to engage in meaningful activity. Some people said they were 'lonely, isolated and bored'. People who stayed in their rooms did not have access to appropriate stimulation and occupation.

Parts of the building were in need maintenance. There was no overall maintenance and improve plan, rather the provider reacted as issues arose. **We have recommend the provider follows the Health and Safety Executive guidance 'Maintaining portable electrical equipment 2013.'**

There was a lack of management leadership and a lack of systems to check on the quality of care, which meant people were at risk of receiving care which was not appropriate to their assessed needs and did not follow best practice.

During the inspection we identified nine continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and two new breaches. People were at risk of harm because the provider's actions did not sufficiently address the on-going failings. There has been on-going evidence of the provider's failure to sustain full compliance since 2011. We have made these failings clear to the provider and they have had sufficient time to address them.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. We found not all actions had been taken to ensure the service was safe since the last inspection.

Risks to people's health and wellbeing were not always identified and actions to minimise risks were not always taken. Incidents of potential abuse were not always referred to appropriate authorities and acted upon, which meant people were exposed to further risk of harm.

Medicines were not managed in a safe way to ensure people were protected from risks associated with unsafe management of medicines.

Staff recruitment was not robust and staffing levels were not assessed to ensure they were sufficient to meet people's needs.

Is the service effective?

Inadequate

The service was not effective. We found not all actions had been taken to ensure the service was effective since the last inspection.

People's rights were not being protected through the application of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards.

People's health and welfare needs were not always met. People were being cared for by staff who had not received the training and information they needed. This meant staff did not always have the necessary skills and knowledge to meet people's needs.

People's nutritional needs were not always being met. People were not always adequately supported with their nutrition and hydration needs.

Is the service caring?

Requires improvement

The service was not always caring. We found not all actions had been taken to ensure the service was caring since the last inspection.

Institutionalised practices had developed which did not always support people's individual needs, choices or dignity.

People felt staff were kind and caring and staff demonstrated kindness and a willingness to be able to do more for people.

People were able to keep in contact with their families and friends through unrestricted visiting.

Is the service responsive?

Requires improvement

The service was not consistently responsive. We found not all actions had been taken to ensure the service was responsive since the last inspection.

Summary of findings

People's care plans did not consistently reflect a comprehensive, complete or person centred approach to assessing and meeting people's care needs.

The activities available for people were limited and were not suitable to stimulate and engage them in improving their wellbeing. Staff interactions with people were limited and not always person centred.

People were able to raise concerns; however complaints about the service were not managed in a consistent way.

Is the service well-led?

Inadequate

The service was not well led. We found not all actions had been taken to ensure the service was well-led since the last inspection.

In the absence of a registered manager, the provider had not ensured the service had been managed effectively. Prompt and effective action had not been taken to address the previous beaches in regulation.

Audits and quality monitoring systems were not in place to identify areas for improvement. We identified a number of continued breaches of regulation which should have been identified and rectified through a robust system of quality assurance.

There was no analysis of accidents, incidents, concerns and other significant events so the provider could not evidence they had learnt from these.

The service had not always informed the Commission about notifiable incidents in line with the Health and Social Care Act 2008.

Devonia House 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 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.

Before the inspection we reviewed the information we held about the service, including notifications. Providers are required to submit notifications to the Care Quality Commission about events and incidents that occur including unexpected deaths, any injuries to people receiving care, and any safeguarding matters. This enabled us to ensure we were addressing any potential areas of concern.

This inspection took place on 12, 19 and 29 January 2016 and was unannounced. The inspection team consisted of two CQC inspectors.

There were 18 people living at the home at the time of the inspection. We saw or met with the majority of people using the service and we spoke in detail with eight people. We spoke with one relative, and four health and social care professionals; including a social care practice manager; two community nurses; and a social worker. We also spoke with the provider and 11 members of staff, including the new manager; nursing staff; care staff and ancillary staff.

We observed how people were being cared for and how staff attended to their needs. We joined some people whilst they were having lunch to discuss and observe their experiences.

We looked at eight people's care records, people's medicine records, six staff recruitment records, staff training records and a range of other quality monitoring information.

Inadequate

Is the service safe?

Our findings

At the last inspection we rated this key question as inadequate. There were not enough staff to meet people's needs; staff recruitment was not robust; medicines were not managed safely; not all incidents had been reported appropriately and individual risks had not always been assessed and identified.

At the last inspection we found a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to demonstrate they had carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels.

Prior to the provider's decision to cease providing nursing care, registered nurses had been responsible for assessing people's needs; developing care plans; the management of medicines and directing the delivery of care and leading the shifts at the service. Since December 2015 there had not always been a registered nurse on shift. This meant additional responsibilities were expected from care staff, in particular three senior care staff to coordinate the care at the home. Staff explained they had received little or no support or additional training to help them understand their new responsibilities when the service transitioned from nursing to residential care. One said, "The handover arrangements have been poor. There has been no real support or information for care staff." This was echoed by other staff we spoke with. Staff felt anxious and worried about the additional responsibilities expected of them and they said communication had been poor about the changes. This meant there were not always enough qualified, skilled and experienced staff on duty to meet people's needs.

A review of the staff rota for December 2015 and January 2016 showed staffing levels were not consistent. For example the number of staff on an early shift (from 07.00am to 2pm) varied from between three staff to five staff on occasions. There were similar inconsistencies in relation to late shift (2pm to 7pm) with variations between five and two staff on duty. Staff said they did not feel there were always enough staff on duty. One member of staff described the recent staffing levels as 'horrendous…' Another said staffing had been "Fairly dire. A lot of staff left at once." We asked staff how they managed when it was "dire". One said, "It gets done but the timeframe is longer." Another said "We want to do more, be more interactive, have a chat, give people company. It feels they have become institutionalised." A visiting professional said they were not confident that the provider had maintained staffing levels to ensure there were always sufficient staff on duty.

We spoke with staff about the dependency levels and the care and support needs of people using the service. Staff confirmed that eight people required the assistance of two staff for safe moving and handling and for personal care. Three people required full assistance at mealtimes to ensure they ate adequately. A further three people required supervision and prompting at mealtimes. Staff explained when there were three staff on duty it was difficult to monitor people or respond to their requests quickly. One staff member said, "It is constantly busy. You can't spend time with people. Staff give their best…"

During the inspection we observed little interaction between people using the service and staff, except when care and support was delivered. One person sat in their wheelchair in the lounge from 10.30 until 2.15pm.From 10.30 until 12.30 they were alone in the lounge. The care plan for this person stated they were living with dementia; they had distressed periods and enjoyed being in the company of others. During this period of time the only staff contact the person had was when staff moved them to the dining table at lunchtime. At one point during the morning the person showed signs of being cold. We alerted staff to this as there were no staff present in the lounge for significant periods. At other times the person became distressed and restless, trying to get out of their wheelchair. Again we had to alert staff to the person's needs as staff were not present in the lounge. A person who chose to spend the majority of time in their room said they thought the service was "short staffed." They said staff were "…always rushing around…" and did not have time to spend "chatting." However they added that all staff were "very good" to them.

Staff explained they were responsible for making and serving breakfast and for preparing, serving and clearing up after supper. They said these chores took them off the floor and meant they had less time with people using the service.

Visiting professionals raised concerns about staffing levels. They felt there not always enough staff on duty to meet

people's needs. One said, "It feels as though the staff are firefighting so unable to do additional sociable things with people." Another said, "People are clean and washed but there are not enough staff on duty at times." They said this meant people's conditions were not always monitored and responded to.

On the first day of the inspection the duty rota showed three staff were booked for the early shift on 15 January 2016 and just one member staff was on duty for the late shift. On 16 January 2016 two staff were on the rota from 7am to 7pm. We spoke with senior staff about the rota; they said they did not get involved in planning the rota. We spoke with the provider, who was unaware of the situation and said they did not get involved in planning the rota. Therefore there was no oversight by senior staff or the provider to ensure there were sufficient staff on duty. Once brought to the attention of the provider, additional agency staff were booked to cover the shifts. The duty rotas showed there was no senior member of staff on duty on 1, 3 and 8 January 2016. This meant there was not always a senior member of staff on duty to organise the team and lead the shift. This meant the provider had not organised staffing arrangements to ensure people's needs could be met consistently.

These findings evidence a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

On the third day of the inspection, the new manager confirmed the responsibility for the staff rota would be taken over by them within a week. They planned to assess the staffing needs for each shift to ensure adequate staffing levels were maintained. Following the inspection the manager confirmed the preferred staffing levels of four care staff and one senior for the early shift, and three care staff and one senior for late shift had been established. They had also employed a part time activities co-ordinator and a kitchen assistant was being appointed to release staff from preparing, serving and cleaning up after supper.

At the last inspection we found a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were put at risk of harm because some risks had not been appropriately assessed and actions taken to minimise the risk.

At the last inspection people were at increased risk of developing pressure damage because pressure relieving mattresses were not used appropriately. At this inspection we found the settings for people's pressure mattresses had not been assessed and recorded in care plans to ensure they were correct. On the second day of the inspection we checked six people's mattresses. Two were set at the highest setting and four were set to just over a medium setting. One mattress was set at the highest setting although the person using it weighed 45.5kgs, which would mean the mattress had been set too high. Staff were unaware of what the correct settings for mattresses should be. We asked the provider to ensure the mattress settings were reviewed as a matter of urgency to ensure they were correct. However on the third day of the inspection the mattress settings had not been reviewed. If mattresses were not set correctly, according to people's weights, and if they were 'too hard', people would not receive the therapeutic effect intended.

Important information was missing from care plans. For example one person was described by staff as having occasional "coughing fits" when eating. Staff said they thought advice had been sought from a Speech & Language Therapist (SALT). However they were unaware of the advice given by SALT, a copy of which was in the care plan. Advice included ensuring the person sat upright for meals and ate slowly. During the inspection this person was observed to have all their meals in bed, and they were not supported to sit upright.

Some people using the service had fallen or had other accidents in the months prior to this inspection. Those who had fallen, or who had been identified as at high risk of falls, had no clear care plans in place to guide staff on what measures should be taken to reduce the risk. Care plans and risk assessments had not been reviewed following accidents such as fall, to ensure staff were aware of the correct actions to reduce falls. The service had not obtained the advice or input of external professionals such as the 'complex care team or 'falls prevention team', who could have supported them to look at ways in which falls could be reduced.

Records showed one person had slipped from their chair. The care plan stated they were "at high risk of falls." However, the person's 'mobility/restlessness' care plan had not been reviewed since the incident. Records for another person showed they had an accident where furniture fell on

them but their risk assessment in relation to falls was not reviewed. Nor was a new risk assessment considered in light of the accident. Current and archived records were searched to look for the daily record of the accident but it could not be found. There was no information in the person's care records about the action taken to reduce this particular risk and staff were unaware of any specific actions needed to prevent a similar accident.

Information we viewed and discussion with staff confirmed one person displayed behaviour that challenged the service, such as physical and verbal aggression. The care plan did not contain sufficient guidance for staff on the actions to take to help protect the person and others in a consistent way. There had been an incident where the person had 'physically attacked staff', however the care plan and risk assessment had not been up-dated following the incident, nor had strategies been considered for responding to the person's behaviour. Detailed information about any triggers relating to the behaviour or how to reduce the risks of it occurring were not contained in the care plan. There was no guidance about how to support the person if they became restless or distressed. A new member of staff said they had been told very little about the person or how to respond should they display aggression.

People's weight was not being monitored regularly and action was not always taken to address any weight loss. There were significant gaps in the monthly and weekly weight records. Some people had three weight records, kept in different places, which were contradictory. This meant it was difficult to establish the actual weight on a given date. One person had lost over 7kgs between June 2015 and December 2015. Weight records showed this person should have been weighed weekly but this had not been done over the six month period. However monthly weights had been completed, with the exception of one month. We were unable to confirm from the records whether this loss had been discussed with the GP. Two senior members of staff were unable to confirm if the GP had been contacted for advice as registered nurses had been responsible for liaising with GPs. They said they thought the person was being offered supplement drinks although these had not been prescribed and there were no records to confirm that additional nutritional supplements were being used.

Another person's weight had not been monitored once in a seven month period. Staff explained this person was sometimes reluctant to be weighed. However no alternative method of monitoring the person's weight, for example using the body mass index (BMI), had been explored. We found this person had a low weight and had been identified as being at risk of weight loss. This meant risks to people's health and wellbeing, such as weight loss, were not monitored to ensure the correct action was taken to reduce the risk. One person's weight loss had been reported to the GP and they had prescribed medicine to help with the person's underlying condition to address the concern.

Domestic staff were at risk of injury because the service did not have suitable arrangements and guidance in place in relation to Control of Substances Hazardous to Health (COSHH). Domestic staff were using cleaning substances in unlabelled containers. When asked, one member of domestic staff said they did not know what the substances were they were using. They had not received training related to COSHH and had not seen any guidance.

The provider's action plan stated improvement would be made to ensure 'Personal Emergency Evacuation Plans' (PEEPs) would be in place by 17 August 2015. However, this had not been achieved at the time of this inspection. There were no PEEPs in place and staff confirmed they had not been given information about PEEPs. This meant care staff and emergency services staff may not be aware of the safest way to move people quickly should they need to be evacuated in the event of a fire or other emergency. A file called 'Emergency and Crisis Policy' had a date of August 2011 and was out of date. For example, the building to be used for an evacuation closed in October 2015. A list of equipment was dated 2013.

The provider's action submitted following the inspection in April 2015 stated improvement would be made to ensure the safe management of medicines. It stated this would be achieved by 17 August 2015.

At the focused inspection conducted on 11 November 2015 we found people's medicines were not managed safely and the planned improvements had not been fully implemented. People had not always received their medicines in the way prescribed for them. There were no systems in place to guide care staff on how to apply creams or other external items and no system to record when these were applied to people. Some medicines were not stored

securely or within the guidance of the manufacturer. Staff did not consistently sign the medicine administration records to show people had taken their medicines as prescribed. The provider submitted an action plan which stated they would be fully compliant with medicines safety by 30 April 2016.

During this inspection we found one person had tablets left in a pot in their room; we confirmed from their medicine records they were paracetamol. Their care plan said they would ask for additional paracetamol. However, because there was no record of when the person had actually taken the medicine it was difficult to determine if the correct time lapse between doses had been maintained. Unless staff monitored to ensure people took their medicines once administered, there was a potential that medicines could be taken by the wrong person or used inappropriately. Another person came to the medicines room at 10.30 asking for their medicines as they were late. The next 'medicines round' was at 12.30, which meant some people might not be receiving their medicines at the time prescribed.

Where staff had handwritten entries onto the medicines administration records, these had not been signed by the member of staff responsible or countersigned by another to ensure accuracy and accountability.

These findings evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

People said they felt safe. Comments included, "Yes, I feel safe. If I press my bell I get all the help I need…"; "…no reason to think I am not safe here…" and "The staff are nice. They make sure I am safe." One person said they felt safe when staff helped to move them using equipment, such as the hoist. They added, "The girls are gentle and make sure I am alright…"

People were not protected from abuse or avoidable harm. There was no safeguarding policy for staff to refer to; staff had not received training or up to date training about safeguarding, and incidents in which people experienced harm had not always been reported.

Some staff knew how to respond to concerns relating to safeguarding saying, "We would talk to a senior or phone CQC or social services". However, a senior member of staff said they would be unsure of what action to take should a safeguarding concern be reported to them. They had not seen the poster displayed in the staff office with the contact details for the local safeguarding team. The provider was aware of the action to take should any concerns be reported to them.

A record in an accident book stated a person was "moved with force" and had sustained bruising. This indicated that abuse may have occurred; at the least poor moving and handling practice. This had not been reported to the local authority safeguarding adults' team, or notified to the CQC. This showed staff lacked understanding that the incident was cause for concern; it had not been followed up in a way which kept people safe. The provider was unaware of the incident as it had not been reported by the staff on duty.

These findings evidence a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not followed safe recruitment procedures to ensure the risk of employing staff unsuitable for their role were minimised. Staff recruitment records did not contain all of the necessary information to ensure people were protected from unsuitable staff. For example, one personnel file did not contain evidence of satisfactory conduct where they had been employed in a care position. References obtained were personal, provided by friends or people who knew the applicant in a personal capacity. Two members of staff had worked previously at the service and returned three and seven months later. No recruitment process had been followed for these members of staff on their return to the service. There was no information on file about how or where they had spent the previous months. Another file contained no references although the application form contained the contact details for two referees. We discussed staff recruitment with the provider, who explained they were not involved in the recruitment process; this was a task delegated to the previous acting manager. There was no system in place to ensure recruitment processes were monitored to ensure they were safe.

Inadequate

Is the service safe?

These findings evidence a breach of Regulation 19 Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

Parts of the building were in need of attention. However the provider did not have a maintenance or improvement plan in place to show how issues were to be addressed. For example, the ceiling in one person's bedroom showed signs of water damage and was bowing. The glass roof over the 'library area' had several cracks and this caused leaks in the wet weather. There was evidence of water damage and damp in this area. Staff confirmed that this area often leaked and they used buckets to catch the water. The provider said he was aware of these two problems but there were no plans in place to address. However, on the third day of the inspection, repairs had been undertaken to the ceiling in the bedroom, and quotes had been obtained for the repair work to the library area.

A new fire safety system was being installed at the time of the inspection. The fire safety equipment, for example, fire extinguishers, had been serviced in December 2015. The provider confirmed that monthly tests were undertaken for the emergency lighting; the fire alarm and automatic door release devices. However, fire safety records showed that regular testing of the fire safety system had not been completed. Records showed the last testing of this equipment had been completed in August 2015. The provider was unaware of this and said it would addressed.

We confirmed that portable appliance testing (PAT) testing had not been done since 2014. PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use. Although there is no requirement for annual testing of portable appliances, there was no assessment of risk to support how the decision when to PAT test was made. Where items are used more frequently there may be a need for more frequent testing, for example, records showed the recommended testing for pressure mattresses was due in December 2014. However this had not been completed. **We recommend the provider follows the Health and Safety Executive guidance 'Maintaining portable electrical equipment 2013.'**

Inadequate

Is the service effective?

Our findings

At the last inspection we rated this key question as inadequate. The service was not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs) and associated Codes of practice. People were not always supported to ensure they had sufficient amounts to eat and drink. Aspects of people's health care needs had not been monitored effectively. Staff had not received regular training, supervision or appraisals to support them to do their job.

At the last inspection we found a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's rights had not been protected under the Mental Capacity Act. The provider's action plan stated they would be compliant with this regulation by 30 November 2015.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who 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.

At this inspection, we found people's rights were still not being protected under the MCA. There had been some capacity assessments undertaken by external professionals but no information to show that staff had undertaken any assessments of people's capacity to make decisions. A member of staff told us one person was "very difficult to understand" and their records showed they had 'severe' communicating difficulties and had a communication aid to help with communication. The staff member said they explained what was being done as care was being delivered and the person was "quite compliant". The person had signed a consent form to receive (generic) care and treatment in 2012; it did not specify what care and treatment and had not been reviewed. There was no information indicating an assessment of their capacity or that staff had helped the person to make decisions.

Relatives (and others) can only give consent where they have the legal authority to do so, for example through a valid Lasting Power of Attorney or appointment as a Court of Protection 'deputy'. Recorded 'best interests' decisions or other valid processes are required in other circumstances. However, there was no evidence that best interest processes had been followed; staff were not aware of any and no records of such were seen.

Staff confirmed they had not received training in the MCA. They did not understand their responsibilities with regard to upholding people's rights where a lack of capacity to consent to care and treatment was probable. For example, if the person was living with advanced dementia. **These findings evidence a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.**

The manager said they knew staff engaged with people about the possible impact of declining care or treatment and "talked through every step with them". This was so people, able to make informed decisions, had the information they needed to do so. In some people's daily records staff had recorded they had obtained people's consent when delivering care. This showed some staff were considering the issue of consent.

At the last inspection we found a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan submitted in August 2015 stated applications had already been completed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under MCA. The application procedures for this in care home are called the Deprivation of Liberty Safeguards (DoLS).

The service had a keypad lock on the front door placed there to restrict one person, who had been intent on leaving, from doing so. However, other people were not free to leave. Many people were subject to continuous supervision and control. For example, bedrails were in use and staff call devices monitored when a person moved around their room. Devices such as these can be helpful when used as part of carefully assessed, individual care planning. However they should not be used without consent, or an assessment of the potential to restrict the

person's free movement. Without consent, an authorisation to restrict the person's liberty is required under the MCA. No applications for authorisation had been submitted.

One person was described as being "mobile and restless" and staff would escort them to leave the building on occasions. Staff had been advised to contact the DoLS team in August 2014 by social services. Following our last inspection we asked that an urgent DoLS application be submitted for this person. The person's care plan, dated April 2015 included that a, "urgent" request for DoLS was being requested. Staff thought an application had been requested but were unable to provide any detail. We confirmed through the DoLS team that a DoLS application had not been submitted to them for assessment and authorisation. Therefore, people were being deprived of their liberty without authorisation.

Staff confirmed they had not received any DoLS training. They did not understand they were depriving people of their liberty without authorisation. An undated policy called 'Restraint' did not include any information about MCA and DoLS to help inform them.

The service did not have a policy or procedure in place to guide staff about the MCA or DoLS. There was a 'framework' entitled 'safeguarding from Deprivation of Liberties' in a policy file in the main office but staff were unaware of this and had not seen or read the 'framework'.

This demonstrated that the principles set out in the MCA code of practice were not being adhered to. **These findings evidence a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.**

The manager informed us that a visit from the local authority MCA and DoLS team was arranged for the near future to provide some advice and training.

At the last inspection we found a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan stated they would be compliant with this regulation by 30 November 2015.

Arrangements for ensuring people received an adequate diet put people at risk. Records were poor and there were several gaps where nothing was recorded on various days for a number of people. This made it difficult to assess whether people were receiving sufficient nutrition to maintain their health. Staff could not be clear what people had to eat and drink because the arrangements for monitoring people's diet were inadequate. For example, staff explained one person would occasionally insist on staying in bed and not eat and drink. Some staff believed the person had nothing to eat or drink the day before our visit. The person then vomited during the night and which would further dehydrate them. A senior care worker said they could not be definite about quantities of fluids taken because different staff would take and remove the person's tray; domestic staff confirmed this. The person's records showed they had eaten porridge and had "400 mls" of fluid on the 17 January 2016 and "200 mls" of fluid only on 18 January 2016. There was no clear guidance about how much fluid the person required each day. The senior care worker in charge was unaware of this low level of fluids when we told them. They said they would seek medical help for the person if they were unresponsive or if they vomited again. They said it was for all staff to monitor fluid levels but…"Records were not kept well yesterday."

Arrangements for ensuring people received adequate fluids put people at risk. A community nurse said they had concerns about the hydration of one person and as a result of inadequate fluids the person was susceptible to urinary infections. The community nurse had prompted staff to monitor and encourage the fluid intake of this person to ensure they received sufficient fluids. Records did not provide guidance for staff about the recommended fluid intake and staff were confused about what the daily in-take should be. One said they thought it was about a litre of fluid; another said it was two litres. The records contained several gaps and did not always record the amount of fluids taken. For example 'tea' was written but not the amount. The records for one person showed they had received 430mls on one day. The following day only 70 mls had been recorded. The fluid chart had not been totalled to show the person's input and output to enable health professionals and staff to judge if sufficient fluids had been taken.

Some people had been prescribed nutritional supplements. The instructions on the medicines administration records state, "use when required." There were no additional instructions in care plans to guide staff when to offer the supplements. From the records we could not be confident that people were receiving the necessary supplements. For example, one person was prescribed

supplements twice a day when required. Staff explained this person received one supplement daily but was reluctant to take the evening one. Staff had not explored with the person when they would like to take the supplements and so they received one a day. The person had lost seven kilos between May and October 2015. There were no other weights recorded after October 2015 to monitor any further loss or gain. Records were poor and did not provide reassurance that people were receiving their supplements regular. This put people at risk of further weight loss.

People were not always supported to eat their meals in comfort. For example, we visited one person in their room and found they were slumped in bed and their breakfast cereal bowel and the contents had been spilt over them. They were wet and uncomfortable and had been unable to eat the breakfast given to them. We alerted staff to this immediately. The care plan for this person stated they required 'support and encouragement' at mealtimes, however, we found their meals were left on their bed table by staff and no support or encourage was provided during our observations of mealtimes. Another person was eating their lunch in bed; we found they had difficulty managing this and looked uncomfortable as they were not supported to sit up straight. They said, "I usually manage…" When asked why people were not supported to sit in their chairs for meals, staff said, "This is their choice…"

These findings evidence a breach of Regulation14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

Most people were positive about the quality and variety of food served. Comments included, "The food is…Good to excellent"; "The food is good most of the time…" and "Lunchtime meals are alright but I would like something different for supper…I usually have soup and sandwiches…" The daily menu was displayed on a board in reception but the majority of people stayed in their room and did not have the opportunity to see the choices. One person said they did not always know what the main meal of the day was. Other people said staff told them about daily choices and they were able to order what they preferred. The chef was aware of people's dietary needs, allergies and preferences. They said there were usually two choices for the main meal most days. There was a four week menu cycle. People using the service were not involved in reviewing or planning menus to ensure they had their say about the type of menus they would like.

At the last inspection we found a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan stated they would be compliant with this regulation by 30 November 2015.

At the inspection in April 2015 staff had not received regular training, supervision or appraisals to support them to do their job. This had been an outstanding requirement from the inspection in October 2014.

At this inspection we found staff had not received appropriate training and did not always have the knowledge and skills necessary for them to carry out their roles and responsibilities. It was difficult to confirm the training staff had received since the last inspection as there was no overall record of staff training. The provider was unable to confirm what training had been delivered. Some staff were able to confirm that they had completed fire safety; moving and handling and a three hour medicines management session since the last inspection. However, four staff had not received training or up-dates to help support them with their roles and work safely with people. For example, moving and handling; safeguarding adults; Mental Capacity Act 2005 and DoLS, first aid or infection control. Staff involved with the preparation of food had not completed food hygiene training to ensure adequate standards were maintained. Staff confirmed moving and handling training had been arranged for the week after the inspection. However they were unaware of any other planned training. Domestic staff had not received training to ensure they worked safely, for example, Control of Substances Hazardous to Health (COSHH), health and safety or infection control.

Staff had not received training or up-dates in relation to the needs and conditions of people using the service, for example, dementia care; diabetes, skin care, catheter care or managing behaviour which may challenge the service. Two visiting health professionals said staff were caring but they were concerned about the care of some people. They said staff did not always appear to understand 'simple' things, for example when a person's catheter leg bag should be changed. They were concerned that staff were not recognising when people were at risk of developing

urinary tract infections. Health professionals said staff needed prompting to ensure specimens were taken and sent for analysis so people could receive the treatment they needed in a timely way. One professional said, "I do wonder how competent some staff are…" All staff spoken with were keen to develop their skills and knowledge and eager to undertake training. One said, "We would like more training and development..." Another said they were hoping to obtain a formal health and social qualification. They said, "I would like to. I keep chasing for it." However, there were no plans in place to help develop staff's skills and knowledge.

There was no formal induction training in place to support new staff. The provider was unaware of the Care Certificate, a nationally recognised set of standards for staff induction to help build their skills and competence when they first starting work at the service. At the time of this inspection one staff member had completed a two day induction, which consisted of shadowing other staff. This person had not previously worked in a care environment. Although they described other staff as supportive, they had not received any training or seen any policies and procedures relating to the service. Nor had they been given an opportunity to look at people's care plans to help them begin to understand people's needs.

None of the staff we spoke with had received supervision and therefore had not had an opportunity to discuss their development or support needs or hear feedback about their performance. Two members of staff who had worked at the service for several years said they had never been offered supervision.

These findings evidence a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

At the last inspection we found a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan stated they would be compliant with this regulation by 17 August 2015.

People's health needs were not always monitored or managed effectively. People had access to health professionals in order to meet their health care needs although referrals to professionals were not always made in a timely way. GPs, community nurses, mental health professionals; speech and language therapist; opticians and dentists had been involved in people's health care.

Information in the care plan for a person, who had experienced and was prone to urinary tract infections (UTI), did not detail how to recognise this or the actions staff should take to prevent reoccurrence. For example the amount of fluid they required daily to help prevent the occurrence of urinary tract infection. Community nurses explained staff were sometimes slow to respond to requests for health screening test, for example tests to diagnose urinary infections. One professional said, "We asked for a sample to be taken on Monday following concerns about one person, but this wasn't done until Friday." This type of delay could put people's health at risk. Another health profession said staff did not always manage catheter care well. They said they were not always alerted when there were problems, for example if the catheter became blocked. This meant there could be an additional risk that people's health would deteriorate further before they were seen by health professionals and appropriate action could be taken.

One person had been admitted to the service due to a medical condition which meant they were at risk of falls. The care plan and risk assessment did not mention the condition or how staff should monitor or manage the person's condition. Staff were unaware of the person's support needs in relation to their condition. This meant that the person was not being appropriately supported to reduce their risk of falling. **These findings evidence a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.**

Requires improvement

Is the service caring?

Our findings

At the inspection in April 2015 we rated this key question as requires improvement. We found several concerns, including poor consultation with people, some poor interactions and people's privacy and dignity was not always being maintained.

At the last inspection we found a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan stated they would be compliant with this regulation by 30 September 2015.

At this inspection comments from people about staff's approach and attitude were generally much more positive. However, we found that people continued to be treated without consideration of their preferences, autonomy and independence, or respect for their dignity and further improvements were required. We identified care practices that affected people's ability to be able to make decisions about their daily routine and lives. For example, the vast majority of people spent time in their bedrooms, many spending long periods in bed.

Care plans did not contain information about people's preference for staying in their room or in bed or detail their preferred daily routine. Staff said it was people's choice whether they stayed in their room or in bed. However, one person said they remained in their room because there was nothing to do in the communal areas. They said they sometimes felt "isolated and lonely." They said staff only came to their room to help with their care or when delivering food, they said staff did not have time to spend with them.

Another person was unsure why they spent so much time in bed and said they would like to get out of bed. They said, "I think it is probably more convenient for me to be in bed…" When asked who it was convenient for they said, "The staff…" A visiting health professional said, "People shouldn't be in bed all day…" They said there was no medical or nursing reason for two people to spend the majority of time in bed. A member of staff said, "We want to do more; be more interactive; have a chat; give people company. It feels they have become institutionalised."

People were not always supported to express their views. People using the service and staff confirmed that 'resident and family meetings' had not been held to discuss the service or share ideas or comments for improvement. No records could be found of when the last meeting had been held. This meant opportunities for feedback were limited which restricted how much influence people could potentially have in how the service was run.

These findings evidence a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of the inspection one person spent four hours sitting in their wheelchair; for a significant amount of this time they were alone in the lounge. We asked a senior member of staff why this person had not been moved to a comfortable chair. Staff explained they did not use the hoist in the communal area as they felt it did not protect people's dignity. However, staff had not explored ways of maintaining people's dignity and privacy when using equipment to assist with moving them. At times the person became restless and distressed and tried to get out of the chair. At one point after lunch the person was slumped in their wheelchair at the dining table and appeared very tired and subdued. This practice did not promote the person's comfort or dignity.

People's dignity was not always upheld. One person had very dirty spectacles, there was food on their clothes and they had a sticky eye which needed cleansing. This had not been identified and addressed by staff. Another person had been left alone with their breakfast in bed. The cereal bowl had fallen onto to them and they were wet and covered with food, which was not dignified. We alerted staff that the person required their assistance.

These findings evidence a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

Several people made positive comments about the staff. We were told staff were caring, kind, polite and friendly. Comments from people using the service included, "Staff always ask if there is anything they can do"; "The girls are kind and friendly even if short staffed…"; "The staff are all lovely…all very good to me…" and "I am looked after…all staff are kind me…" External professionals also said staff's approach was caring. One commented, "Some staff are excellent, even the cleaners…the banter is friendly and this provides an emotional up-lift for people…staff are compassionate…they are doing their best…" Another said,

Requires improvement

Is the service caring?

"The staff are caring. There is no issue there…" Visiting professionals said the standard of personal care was usually good, one said, "People are clean…personal care is done…"

Relatives and friends were made welcome and visited regularly throughout the inspection. They were offered refreshments including an offer of hot meals.

Overall, people's positive comments showed there had been improvements in staff's attitude and approach since the last inspection. However we found that people continued to be treated without consideration of their preferences, autonomy and independence, or respect for their dignity and further improvements were required.

Requires improvement

Is the service responsive?

Our findings

At the last inspection we rated this domain as requires improvement. Care plans did not contain sufficient and relevant information; people did not have an opportunity to contribute to the planning of their care and people's social needs were not met as there were limited opportunities for social activities or occupation.

At the last inspection we found a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan stated they would be compliant with this regulation by 30 September 2015.

We looked at the pre-admission assessment completed for one person admitted to the service since the last inspection. The person said they had been involved in a discussion about the assessment of their needs although they were not aware of their care plan. The 'pre admission assessment' had been completed in pencil and was not comprehensive to enable a care plan to be developed. There was nothing about the person's medical condition, which had caused their admission. This meant there was a risk staff would not have the information they needed to care for this person appropriately.

Care plans are a tool used to inform and direct staff about people's health and social care needs. Staff said they did not see people's care plans, which were in the office, and a new staff member said they had not been informed about the care plans. Care plans were not, therefore, being used to inform and direct staff about people's health and social care needs.

Each person had a care plan but they lacked detail about their needs, preferences and wishes. For example, where medical conditions were mentioned, such as diabetes or depression, there was no explanation as to the impact each condition could have; what indicators staff should look out for, or how to respond in the event of concern about the person's health. One person exhibited behaviours which were a challenge to staff and their safety. The person's care plan stated the person could become confrontational but did not provide staff with a plan of how to prevent, or manage, such confrontation. A member of staff, who was not familiar with the person, knew they had to "be cautious". They were not aware of what could trigger aggressive behaviour and so could not avoid it.

People's care records had not been reviewed and up-dated although their needs and risks had changed. For example where people were at risk of dehydration or where daily records showed they had developed minor skin pressure damage. As care records were not always fully completed or up to date, people were at risk of not having their needs met.

People did not have an opportunity to contribute to the planning of their care. None of the people we spoke with were aware of their care plan. People's preferences were not recorded; as a result care plans and the care delivered were task-oriented and not person centred.

At the last inspection we recommended that the service seek advice and guidance on developing activities for people living with dementia. However this recommendation had not been acted upon.

The care and support provided was not person centred or designed to ensure people's social, emotional and psychological needs were met. People had little stimulation, social activity or company. One person spent up to four hours in the lounge alone talking to themselves. Their care plan said they experience periods of distress and enjoyed being in the company of others. At our third visit they were sitting alone in their room in front of a television talking to a doll. The person responded very positively to the attention we gave them. Over the three days of the inspection we observed this person was not involved in sociable activities nor did staff spend time with them on a one to one basis.

One person said staff didn't have the time to organise activities or spend time chatting or being sociable. They added, "I would like something to do…some pleasure and enjoyment. If there was something going on you can get to meet and know people…it can be lonely here…" They could not recall when they had last been offered an opportunity for social activities. Records showed they had not been engaged in social activities since August 2015. Another person said they felt "lonely and isolated" at times. Records showed this person had attended a birthday party and Christmas party but no other social activities since June 2015. People said they had not been offered opportunities to enjoy trips out to familiar places or places of interest. Staff confirmed there had been no outings arranged or planned since before the last inspection in April 2015.

Requires improvement

Is the service responsive?

On the first day of the inspection four or five people had gathered in the lounge for a game of Scrabble, which was facilitated by a member of care staff. People said that although they enjoyed this activity, it was not a regular occurrence. One person said, "We don't do this regularly as they are sometimes short of staff…" A member of staff said 'there was not much going' to help people enjoy sociable time. They added, "…it's a missed opportunity as when people do come together some people tend to eat more as it is more sociable…"

Records showed that during the past seven months, between two and four activities had been undertaken each month. Where activities were organised these were aimed at groups of people rather than people's individual preferences. Activities were not targeted at an appropriate level to accommodate people's varying abilities. The records confirmed it was usually the same small group of people who participated, meaning the majority of people did not have access to social activities or occupation.

There was little or no information about people's life histories and previous interests and hobbies available to enable staff to support people, particularly people living with dementia, who may be unable to recall details of their past life independently. Staff having access to this information could help them to provide more person centred care, including meaningful occupation and stimulation.

These findings evidence a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

The newly appointed manager explained interviews had been held the week of 25 January 2016 for an activities worker and a person had been offered and accepted the post. The manager was confident the appointment would benefit people using the service.

People confirmed they were aware of how to raise a complaint or concern they may have. They said they would speak with staff or with the provider. There was a 'complaints book' for recording any concerns or complaints raised. Since the last inspection, one complaint had been raised according to the records. The nature of the complaint had been recorded; however, there was no information about how the complaint had been addressed or whether the complaint had been resolved for the person. The provider and staff were unaware of the complaint and could not confirm if action had been taken to address it.

These findings evidence a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the last inspection we rated this domain as inadequate. There had been no registered manager at this service since December 2013.The service lacked leadership, guidance and direction and there were not always clear lines of accountability and responsibility. There were no effective systems in place to monitor the quality of service delivered and there was no effective analysis of accident and incident to help prevent further accidents and incidents in the future.

At the last inspection we found a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan stated they would be compliant with this regulation by 31 November 2015.

The provider had been unable to recruit a registered manager since the last inspection. A new manager was appointed in October 2015; however they resigned after four weeks. On the first day of this inspection, local authority staff were working with the provider to interview potential interim manager candidates. One was successfully appointed and began work at the service on 25 January 2016.

There was a lack of leadership, governance and quality monitoring systems at the service, which meant some risks were not being identified or responded to. The action plan submitted to CQC following the last inspection had not been met. The service had not maintained compliance in meeting regulations over time. Since 2011, CQC has inspected the service eleven times. One of these inspections was judged as being fully compliant in all the outcome areas that were inspected. At all other inspections there had been breaches of regulations.

There were no effective quality assurance systems in place to make sure that areas for improvement were identified and addressed. For example medication, care plan, and falls audits were not carried out to ensure consistent quality care was delivered.

At this inspection we asked to see accident records. Staff were unable to locate all of these records. During our third visit some additional accident records were found. We looked at how the provider monitored accidents and incidents to minimise the risk of re-occurrence. They told us they did not review these records as that would have been the role of the manager. This meant there was no overall analysis of accidents or incidents over a period of time to identify patterns or trends that may occur. Without details of accidents, trends and themes could not be identified toward improving people's safety.

Record management put people at risk. There was no arrangement in place for systematic review of people's care plans or risk assessments and they were not always reviewed when changes occurred. Three visiting professionals said the records at the service were poor and did not support them with their assessment and monitoring of people's health needs. Other records relating to the management of the service were poor, for example recruitment and training records; complaints and maintenance records. The provider and other staff were unable to produce some records required during the inspection; other records were not easily accessible or were incomplete.

The provider had not developed appropriate methods to monitor and manage the training needs of the staff. There were no systems in place to indicate what staff training was needed and what training had been completed. Staff did not always feel supported by the provider and the provider had not ensured staff received training and support in order to understand and discharge new responsibilities. Staff expressed anxiety about the new responsibilities expected of them.

Policies and procedures, which should support staff knowledge and understanding, were not comprehensive and had not been updated and reviewed as necessary, for example, when legislation changed. This meant change in legislation or practice were not reflected in the home's policies, for example the restraint policy did not mention the Mental Capacity Act 2005. Staff were unsure where to find policies and they confirmed they had not seen the majority of policies.

People who used the service, their representatives and staff had not been regularly asked for their views about their care and treatment. However, recently the provider had distributed satisfaction questionnaires to all people using the service and their relatives. They were unsure how many had been returned or what the feedback indicated. They said they would read them, and then the home's secretary would file them. The provider did not confirm they intended to analyse the feedback or how they proposed to respond to people's feedback. We found five completed

Inadequate

Is the service well-led?

questionnaires had been returned, which highlighted areas for improvement. For example social activities. Some people we spoke with said they could not recall receiving the recent questionnaire. Other stakeholders' opinion had not been sought, for example staff and external professionals. Neither staff nor the provider could confirm when the last staff meeting had been held and no minutes of it were available. Staff thought it was 'before Christmas'. A staff meeting was planned for the week after the inspection.

These findings evidence a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continued breach of regulation.

Staff expressed their confidence in the new manager during the last day of this inspection. They said even though she had been in post for a very short time, she had made a positive impact. Staff said the new manager understood their concerns, she listened and "spoke to them on their level." One staff member said of the new manager "…seems forward thinking and she gets things done." The manager was beginning to prioritise areas for action. She was getting to know the people using the service and staff by working with them and she had up-dated the provider's action plan. The action plan for improvement submitted to CQC by the manager following this inspection showed additional slippage in timescales compared with the original action plan submitted following the last inspection.

The provider had failed to notify CQC of events which stopped the service running safely and properly. On three occasions during December 2015, due to sickness, the service was unable to obtain a registered nurse to cover night shifts. As a result the acting manager stayed at the service overnight on three occasions, having worked a 12 hour day shift. The CQC had not been notified about a potential safeguarding issue. This meant we were unable to monitor the service.

These findings evidence a breach of Regulation 18 of the Health and Social Care Act 2008 CQC (Registration) Regulations 2009.